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In The
Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., A CORPORATION; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., A CORPORATION,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. **HCQIA**. Whether a hospital that engages in anticompetitive conduct is entitled to immunity under the Health Care Quality Improvement Act whenever it believes that its anticompetitive conduct will further quality health care or protect patients.

2. **Hospital-Physician Agreements**. Whether a contract prohibiting truthful, competitively important information, imposed by a hospital on a physician, is entitled to the same deferential antitrust scrutiny as a non-price vertical agreement between a manufacturer and reseller, even though hospitals and physicians do not stand in a vertical relationship and hospitals are not effective surrogates protecting consumer interests.

3. **Potential Competition**. Whether an agreement between two potential competitors may be considered horizontal, subject to enhanced antitrust scrutiny, even though one of the potential competitors has not yet commenced operations.

RULE 29.6 STATEMENT

Petitioners state that they have no parent or subsidiary corporation and that no publicly held company holds any stock of a Petitioner.

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OPINIONS BELOW

The district court issued three opinions on appeal here:

- First, an opinion dated May 21, 2001, that, in pertinent part, denied the Plaintiffs' motion for summary judgment on its claim under Section One of the Sherman Act. *Gordon v. Lewistown Hospital*, 2001 WL 34373013 (M.D. Pa. May 21, 2001), reproduced at App 167-232;
- Second, an opinion on reconsideration of the March 21, 2001 order, dated August 15, 2001, granting the Hospital's motion for summary judgment allowing it immunity, reproduced at App 233-48; and
- Third, an opinion entering judgment for the Defendant after a bench trial. *Gordon v. Lewistown Hospital*, 272 F. Supp.2d 393 (M.D. Pa. 2003), reproduced at App 53-166.

The Third Circuit Court of Appeals' opinion affirming the district court judgments is found at *Gordon v. Lewistown Hospital*, 423 F.3d 184 (3d Cir. 2005), and is reproduced at App 1-52.

JURISDICTION

The Third Circuit's judgment was entered on September 13, 2005. A timely petition for rehearing was filed, and was denied on November 7, 2005. App. 249-50. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant portions of the Health Care Quality Improvement Act, 42 U.S.C. §11151(9), and the Sherman

Act, 15 U.S.C. §1, are included in the appendix at App 251-52.

STATEMENT

A. Introduction.

Petitioners ask this Court to define the type of antitrust scrutiny a court should apply to efforts by hospitals to limit competition among physicians and to prevent competition by a competing facility. The Third Circuit labeled the relationship between a hospital and an independent physician as "vertical," and thus held that any agreement between a hospital and a physician is always subject to review only under a full-blown rule of reason analysis. The relationship between a hospital and a physician, however, is quite different from a traditional vertical relationship between a manufacturer and a reseller. Hospitals and physicians provide different but complementary services to patients. Consequently, hospitals are not neutral with respect to which physician patients choose, and their interests are not necessarily aligned with consumers. This relationship is further complicated by the fact that physicians are increasingly entering into direct competition with hospitals by opening facilities, such as free-standing surgical centers, specialty hospitals and imaging centers.

The Third Circuit granted immunity from antitrust damage claims for any restraint a hospital imposes on a physician, regardless of its anticompetitive nature, and regardless of whether the hospital's conduct is otherwise exempted from the immunity statute, so long as a hospital asserts that its action benefits patients.

With respect to the Sherman Act claim, the Third Circuit was confronted with an agreement between a hospital and a physician that kept critical competitive information from consumers. The Third Circuit, with no

analysis or explanation, erroneously declared that the agreement was a non-price vertical restraint subject to very deferential antitrust scrutiny.

Further, the Third Circuit erred in deeming the restraint vertical, given that the Hospital viewed Dr. Gordon as a potential competitor because he was close to opening a competing surgical facility. Thus, regardless of the nature of the hospital-physician relationship, the agreement between the Hospital and Dr. Gordon was horizontal.

B. Undisputed Factual Background.

1. Competition Among Ophthalmic Surgeons.

The Plaintiffs include not only a physician, Dr. Alan Gordon, but also the surgical facility he now owns and was developing during the events at issue here. The defendant Lewistown Hospital is the only hospital in Mifflin and Juniata counties in Pennsylvania (App at 3), with a dominant market share in a concentrated market. Much of this case is about the Hospital's effort to maintain its dominant position.

There are only two ophthalmologists in Mifflin and Juniata counties, Dr. Gordon and Dr. Paul Nancollas. App at 4. Dr. Gordon is "widely respected as a surgeon," whose "medical competence is not at issue in this case." App at 58. Unlike Dr. Nancollas, Dr. Gordon is certified by the American Board of Eye Surgeons. *Id.* Dr. Gordon used the more modern phacoemulsification ("phaco") procedure to remove cataracts, which became "the preferred procedure for ophthalmologists" by the mid-1990s. App at 59-60. In contrast, Dr. Nancollas used the older "ECCE" procedure to remove cataracts. App at 4-5. The phaco procedure has a shorter recovery time and "less risk of complications" than the ECCE procedure. App at 5. Dr. Gordon's phaco

procedure "led to a rapid improvement in vision [such that] patients undergoing this procedure generally recovered in two weeks." *Id.* In contrast, recovery from Dr. Nancollas' surgery with the older ECCE procedure "could extend up to three months." *Id.* Likewise, although Dr. Gordon used topical anesthesia, Dr. Nancollas' method required anesthesia "injected into the back of the eye where the physician cannot see the end of the needle, risking damage to the eye and nervous system." *Id.* Dr. Nancollas was employed by an HMO that was the Hospital's largest tenant. App at 58 and 78.

Dr. Gordon competed not only effectively, but vigorously, for patients in the Lewistown area. App at 70-72. Dr. Gordon both advertised to and communicated directly with patients, all truthfully, about the advantages of phaco over ECCE and the anesthesia methods he used. In contrast, as the Third Circuit acknowledged, Dr. Nancollas misled patients by advertising that he "performed 'modern cataract extraction', although at the time he still used the ECCE procedure" that was no longer the preferred procedure for removing cataracts. App at 5. Even more egregious, Dr. Nancollas gave his patients a brochure on cataract surgery that described the phaco method Dr. Gordon used, as though Dr. Nancollas was using it himself. A5117-5118, A8181 (A** citations are to the Appellate record). The Hospital nonetheless criticized Dr. Gordon for being "aggressively competitive" and "adversarial." A86579; App at 6.

2. Dr. Gordon's Proposed Surgery Center.

In November 1995, Dr. Gordon asked the owner of the only stand-alone surgery center in the area, Dr. Everhart, if he could perform cataract surgery at the facility. App at 15. At the time, Dr. Everhart had a "written market allocation agreement with the Hospital" that prohibited him from performing cataract surgery at his facility. *Id.* Dr. Everhart refused to let Dr. Gordon operate at his

facility, and reported to the Hospital Dr. Gordon's intent to open his own facility. *Id.* Before Dr. Gordon could open a new facility he needed a "certificate of need" ("CON") from a state agency. Dr. Gordon filed a CON application in 1996, and both the Hospital and Dr. Everhart opposed Dr. Gordon's CON application while filing their own CON applications to expand their surgical facilities. App at 80-82.

3. The Hospital-Physician Relationship.

A physician cannot practice at a hospital without receiving clinical privileges from the hospital. App at 3. Clinical privileges, however, do not make a physician an employee or agent of the hospital. *Id.* Clinical privileges allow the physician to admit patients to a hospital and to treat those patients at the hospital. *Id.*

Hospitals provide a facility and related services to patients, but they do not provide medical services and do not advise patients on treatment options. *See*, Furrow *et al.*, Health Law, 410-12 (West 2001) ("Health Law"). Many hospitals today "explicitly consider the financial impact of a doctor's treatment patterns in their privilege decisions." Health Law, at 811.

4. The Information Restraints.

In 1996, Dr. Gordon's clinical privileges to practice at the Hospital were up for renewal by the Hospital's Credentials Committee, chaired at that time by Dr. Everhart. App at 67-68. The Hospital refused to renew Dr. Gordon's clinical privileges unless Dr. Gordon would sign a contract (the "Conditions of Reappointment"), written by Dr. Everhart. App at 68-69. They entered into that contract in November, 1996. App at 11. Two paragraphs in the Conditions of Reappointment (the "Information Restraints") barred Dr. Gordon from informing anyone other than two officers of the Hospital about the differences between his

procedures and Dr. Nancollas', or about any concerns Dr. Gordon had with the procedure used by Dr. Nancollas:

> (2) [A] complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Credentials Committee, with a copy to the President of the Hospital.
>
> (3) You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician. Furthermore, other than in response to a specific question or for the purpose of a referral, you shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

App at 10-11. Taken together, these contractual restrictions prohibited Dr. Gordon from providing critical medical advice to his own patients, and from telling potential patients or referring physicians about the differences between his and Dr. Nancollas' procedures or about his concerns with Dr. Nancollas' procedures.

5. Dr. Gordon's Patient Recalls And His Conversation With A Patient.

Dr. Gordon and his office staff would call patients with chronic and degenerative conditions, such as cataracts, to remind them of the need for follow up care (A4684), a practice the Hospital's own expert called "noble" and "admirable." A6253, A6279.

In 1994, Dr. Gordon had examined Margaret Seecora, and diagnosed cataracts in both eyes. App at 74. Mrs. Seecora decided at that time not to have surgery, which is the only way to treat a cataract. *Id.* Over the ensuing years, Dr. Gordon or his staff contacted her occasionally to discuss her cataracts. App at 12 n.7. Eight months after Conditions 2 and 3 went into effect, during such a routine call, Dr. Gordon learned that Dr. Nancollas had removed a cataract in one of her eyes. App at 12. Mrs. Seecora told Dr. Gordon that Dr. Nancollas told her he had used the "most modern methods" and the "drop method" of anesthesia. A4709, A7842, A7869, A8195. That was false. Nonetheless, both the district court and the Third Circuit held that Condition 3 of the contract required Dr. Gordon to hang up the phone at that point. App at 75; App at 12. Mrs. Seecora still needed surgery for her other eye. Dr. Gordon told her that Dr. Nancollas had misrepresented the procedure he had performed, that he was "just learning" the newer method and that Dr. Nancollas' methods had greater risks than the more modern procedure Dr. Gordon used. App at 12-13. No one has ever disputed that what Dr. Gordon told Mrs. Seecora was true. Although the conversation upset her, Mrs. Seecora explained that what she found upsetting was that "it caused her to question her decision to allow Nancollas to operate on her cataract. . . . " App at 28. The district court found that Mrs. Seecora "felt that Dr. Gordon was trying to solicit her to use him to remove her remaining cataract." App at 75.

The Hospital concluded that Dr. Gordon's call to Mrs. Seecora violated Condition 3, allowing the Hospital to revoke Dr. Gordon's clinical privileges.[1]

---

[1] The Hospital asserted another secondary violation when Dr. Gordon circulated a letter to Hospital management in which he raised truthful clinical concerns about Dr. Nancollas' procedures. App at 13.

C. Proceedings Below.

Plaintiffs filed suit asserting several antitrust claims. Pertinent here is Count I, claiming that the Information Restraints in the Conditions of Reappointment violated §1 of the Sherman Act. Jurisdiction in the district court was based on a federal question. 28 U.S.C. §1331.

On cross motions for summary judgment, the district court first denied the Hospital's request for immunity under the Health Care Quality Improvement Act ("HCQIA"). App at 200 and 218. On reconsideration, however, it granted summary judgment to the Hospital under HCQIA, holding it immune from damage claims, regardless of whether the conduct for which the Hospital expelled Dr. Gordon was a competitive act. App at 240-1. With damage claims barred, Plaintiffs' jury demand was stricken.

The case then went to trial in April, 2002, limited to Plaintiffs' injunctive claims. Fifteen months after trial, the district court entered judgment for the Hospital, holding that the contract containing the Information Restraints was "not only reasonable but required" to protect the Hospital from malpractice suits if Dr. Nancollas' deficiencies were exposed (App at 156), and because of the Hospital's "'public service' function . . . to . . . shield patients from the oftentime harsh realities of capitalistic competition." *Id.*

On appeal, the Third Circuit affirmed the holdings of the district court, albeit on different grounds. On HCQIA immunity, it held a hospital is immune from damages, as a matter of law, if the hospital's conduct was designed "to protect patients", regardless of whether it is based on a physician's competitive activity, and regardless of its effect on competition. App at 30-32.

On Plaintiffs' Sherman Act claims, the Third Circuit held that a contract between a hospital and a physician prohibiting a physician from giving patients truthful competitive information is "vertical" and therefore judged under the full rule of reason. Consequently, the court required proof of market power, even though: (a) the hospital-physician relationship bears none of the characteristics of a vertical relationship, and (b) the physician was in the process of entering the surgical facility market as a horizontal competitor of the hospital. App at 41.

REASONS FOR GRANTING THE PETITION

I. The Third Circuit's Expansion Of HCQIA Immunity Conflicts With The Plain Statutory Language.

The Third Circuit has interpreted §431(9) of the HCQIA in such a manner that hospitals and other health care entities will now enjoy blanket immunity from the antitrust laws whenever they assert that their restraints on physician competition are good for patients. 42 U.S.C. §11151(9). The Third Circuit has, thus, decided "an important question of federal law that has not been, but should be, settled by this Court," and its construction of the statute "conflicts with the relevant decisions of this Court," suggesting review under Supreme Court Rule 10.

HCQIA provides a narrow grant of immunity to health care entities, such as hospitals, HMOs and group medical practices that use peer review to maintain quality care. The grant of immunity is limited only to certain "professional review actions" – a term which is carefully defined in §431(9) of the Act. 42 U.S.C. §11151(9). The only issue here is whether the limitations on what can constitute a "professional review action" contained within §431(9), which were designed to protect competition, remain viable.

A. The Third Circuit Has Nullified The Statutory Exceptions Or "Carve-Outs" Contained Within The HCQIA That Were Designed To Protect Competition.

When HCQIA was enacted, Congress understood that institutional medicine had, for generations, used the guise of professional standards to prevent emerging competition.

> Throughout much of the twentieth century, health care was marked by physician prerogatives, patient deference to physicians, and price-insensitive insurance payments. Each of these elements was explained on the grounds that health care was "special" – that the ordinary rules of market exchange simply would not work.
>
> * * *
>
> The initial salvos in the legal battle for health care competition focused on supply-side competition. After consolidating its political power during the early twentieth century, organized medicine waged no-holds-barred campaigns to ward off outside challenges to the autonomy of physicians and their monopoly on licensure. One target was prepaid group practice. . . . Organized medicine also sought to destroy chiropractic treatment. . . .

Sage, Hyman and Greenburg, *Why Competition Law Matters To Health Care Quality*, 22 Health Affairs 31, 34-35 (2003).

It was in this context that the HCQIA was debated in 1986. *See*, Reams, The Health Care Quality Improvement Act of 1986: A Legislative History of Pub. L. No. 99-660 (William S. Hein & Co., 1990) ("HCQIA History"). There was intense opposition by the Department of Justice, driven by the concern that statutory immunity could empower hospitals or other heath care entities to stifle

competition or innovation. *Id.* Consequently, §431(9) the HCQIA contains several exclusions or carve-outs to the definition of a "professional review action" and hence the entitlement to immunity:

> In this chapter, an action is not considered to be based on the competence or professional conduct of a physician [and hence not a "professional review action"] if the action is primarily based on –
>
> (A) the physician's association, or lack of association, with a professional society or association,
>
> (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,
>
> * * *
>
> (D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, ...

42 U.S.C. §11151(9). *See also* 45 C.F.R. §60.3. The exclusions identify physician activity that Congress wanted to protect.

The revocation of Dr. Gordon's clinical privileges was not a "professional review action," and was not entitled to HCQIA immunity if it was "primarily based on [Dr. Gordon's] . . . engaging in other competitive acts intended to solicit or retain business." There was no dispute that the revocation was based on Dr. Gordon's conversation with Mrs. Seecora (and the letter he sent to Hospital management). App at 76. The district court initially held that it was a fact question whether Dr. Gordon's conduct was a competitive act intended to solicit or retain business. App at 196. The Third Circuit

held, however, that it was irrelevant whether Dr. Gordon's conduct was a competitive act "intended to solicit or retain business." App at 31-32. Instead, the Third Circuit stated:

> [E]ven when the solicitation exception is in play, immunity will be judged by applying the objective standard regarding whether the Hospital based its actions upon the reasonable belief they are in the furtherance of quality health care. *See* 42 U.S.C. § 11112(a). . . . The real issue in this regard is . . . whether it was undertaken to protect patients.

Id. As a result, even though Dr. Gordon's conduct was unquestionably a competitive act "intended to solicit or retain business," the Hospital's disciplinary action would remain a "professional review action" so long as the Hospital asserted that it believed that preventing such competition was in "furtherance of quality health care."

The phrase "furtherance of quality health care" however, appears nowhere in §431(9): the section of the HCQIA that defines a "professional review action." The "reasonable belief" of furthering "quality health care" standard is found in §412(a)(1). 42 U.S.C. §11112(a)(1). Section 412(a)(1) identifies the additional standards that a defined "professional review action" must meet in order to receive immunity, and, thus, applies only after it is determined that the hospital's action is a "professional review action" under §431(9). The Third Circuit, nonetheless, held that a hospital's belief that it was "furthering quality health care" is the only requirement needed to qualify an action as a "professional review action."

Under the Third Circuit's interpretation of §431(9), if a hospital believes that preventing protected conduct by physicians such as discounting of fees or advertising will further quality health care or "protect patients", a hospital would receive immunity if it disciplined a physician for those competitive acts. Further, if a hospital disciplines a

physician for associating with nurse practitioners or even osteopaths, its discipline would be a "professional review action" so long as the hospital believed that banning such associations were in "furtherance of quality health care" or would "protect patients." The express exclusions covering this physician conduct in §431(9) become irrelevant.

This case raises a vital question of federal law that this Court has not yet decided. The Third Circuit's holding is that one requirement of immunity (that the action "further quality health care") will trump the express statutory exclusions. This allows the rule to swallow the exceptions. This Court often grants petitions for writs of *certiorari* where the lower court has invalidated an act of Congress. Here, the effect is the same; as a result of the Third Circuit's decision, the statutory carve-outs are no more.

The Third Circuit's interpretation will allow the reemergence into health care markets of anticompetitive practices that federal courts spent the last 25 years trying to uproot. For example, hospitals once refused to grant privileges to osteopaths and other allied practitioners. *See, e.g., Weiss v. York Hosp.*, 745 F.2d 786 (3d Cir. 1984) (affirming antitrust judgment against hospital that excluded osteopaths). Similarly, solicitation of patients was once considered "unprofessional," and contrary to patient welfare. *In re American Medical Ass'n*, 94 FTC 701 (1979), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd by an equally divided court*, 455 U.S. 676 (1982) (striking down medical association's ban on solicitation of patients). The Third Circuit's holding will allow that sort of anticompetitive conduct to flourish because a hospital may impose anticompetitive restraints on physicians with little fear that a physician or patient would have the incentive to challenge the restraint without the ability to recover money damages.

Effective antitrust enforcement, particularly in an era of limited governmental enforcement resources, requires effective private enforcement. *Zenith Radio Corp. v. Hazeltine Research, Inc.*, 395 U.S. 100, 130-31 (1969). As the Department of Justice argued in opposing the enactment of HCQIA in 1986, granting immunity from damage liability may "undermine the incentive and ability of injured parties to redress their harm [and] to insulate anticompetitive activities from antitrust scrutiny." Submission of Ass't Attorney General John R. Bolton to the Judiciary Committee, in HCQIA History, *supra* at 30. Yet the Third Circuit's misguided holdings under HCQIA will deter physicians from performing that vital competitive function, because the hospital will virtually always have immunity, even when stifling undeniably competitive conduct.

Granting blanket immunity to anticompetitive conduct by hospitals is of considerable national importance given the rapidly growing trend, reported in case law, professional journals and the popular press, of hospitals disciplining physicians for speaking out truthfully about quality issues. *See, e.g.*, Rice, *Is Whistleblowing Worth It?*, Medical Economics 58-63 (Jan. 20, 2006); Huntoon, *Abuse of the 'Disruptive Physician' Clause*, 9 Journal of American Physicians and Surgeons 58 (Fall 2004); Twedt, *The Cost of Courage: How The Tables Turn on Doctors*, Pittsburgh Post-Gazette, Oct. 26, 2003; Van Geertruyden, *The Fox Guarding the Henhouse: How The Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. Contemp. Health L. and Policy 239 (2001-2). The Third Circuit's opinion will add fuel to hospital efforts to silence physicians who disclose quality concerns.

B. The Third Circuit Erroneously Placed A Burden Onto Dr. Gordon Of Disproving The Existence Of A "Professional Review Action" And Deferred To The Hospital's Determinations.

The Third Circuit erroneously (1) shifted the burden of proof for the affirmative defense of immunity to the Plaintiffs, and (2) held that, for application of this immunity statute, a court should always defer to the judgment of the hospital.

The Third Circuit held that "the burden is on the [plaintiff] physician to overcome the presumption that the hospital was engaged in a professional review action." App at 32. That holding is unprecedented and wrong. Immunity is an affirmative defense, for which the burden of proof is on the party asserting it. *See, e.g., Moore v. Kulicke & Soffa Industries, Inc.*, 318 F.3d 561, 566 (3d Cir. 2003).

Nothing in the statute creates a presumption that a hospital action is a "professional review action," or shifts the burden to a plaintiff of disproving such a conclusion. The Third Circuit thought §412(a) of HCQIA shifted that burden. App at 32. Section 412(a), however, creates a presumption only that a "professional review action" meets the requirements of §412(a) and thereby shifts the burden under that Section only. Nothing in §412(a) creates a presumption that a hospital's action is a "professional review action" as defined by §431(9), or shifts the burden to a plaintiff to prove that a hospital's action was not a "professional review action." As one commentator explained, "HCQIA establishes a presumption that a 'professional review action' is presumed to have been carried out in good faith . . . [but] that protection is only available to a carefully defined 'professional review action.'" Blumstein and Sloan, *Antitrust and Hospital Peer Review*, 51 Law and Contemp. Prob. 7, 83 (1988). Further, Congress expressly provided in HCQIA that, where the statute is

silent, it leaves traditional immunity burdens and presumptions unchanged. 42 U.S.C. §11115(a). Finally, there is a presumption against implicit and explicit exceptions from the antitrust laws. *Jefferson County Pharmaceutical Ass'n, Inc. v. Abbott Laboratories*, 460 U.S. 150, 157-8 (1983). The Third Circuit's shifting the burden to disprove the existence of a "professional review action" is wrong and stands alone in United States jurisprudence.

Perhaps more dangerous is the deferential standard the Third Circuit created for HCQIA immunity determinations. This Court has made plain that "exemptions from antitrust liability are construed narrowly." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979). Turning that on its head, the Third Circuit held that the courts should defer to the judgment of the hospital seeking immunity as to whether its conduct was a "professional review action": "Nor will this Court substitute its judgment for that of health care professionals and the governing body of the Hospital as to whether Gordon's conduct either did or could have an adverse impact on patient health or welfare" [which the Court held to be the sole determinant of immunity]. App at 29. There is no analog anywhere in the law, where a court interprets immunity so broadly as to defer to the party seeking immunity. The fox is left to guard the henhouse, and then presumed truthful when it denies the feathers in its mouth.

II. The Third Circuit's Antitrust Holdings Misstate The Level Of Scrutiny Applicable To Physician-Hospital Agreements.

This case defined whether hospitals may control competitive efforts among physicians, and between physicians and hospitals. The Third Circuit gave hospitals the same power to regulate competition among physicians that

manufacturers use to control the distribution of their products. The differences between the hospital-physician relationship and the manufacturer-reseller relationship make such an analogy inappropriate.

The Third Circuit's erroneous, and brief, analysis on which the case turned is found in the following passage:

> [E]ven if the Conditions were a restraint, they represent a non-price vertical restraint between one hospital and one physician, which we have held is reviewed under the traditional rule of reason. *See Orson, Inc. v. Miramax Film Corp.*, 79 F.3d 1358, 1368 (3d Cir. 1996) ("[v]ertical restraints of trade, which do not present an express and implied agreement to set resale prices, are evaluated under the rule of reason."). This is especially true given the District Court's determination, with which we agree, that Gordon and the Hospital were not competitors in the relevant market in November 1995 [sic – 1996] when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later.

App at 41. That is wrong for two reasons:

- First, it erroneously equated (i) restraints between hospitals and physicians, with (ii) vertical non-price agreements between manufacturers and resellers, deserving of deferential scrutiny under the rule of reason.

- Second, an agreement between a hospital and a physician about to open a competing facility is horizontal, not vertical, and is subject to heightened scrutiny, even before the

> newly entering facility has actually opened and begun competing.

In making these errors, the Third Circuit ignored existing precedent from this Court, other federal appellate courts and the enforcement positions of federal antitrust agencies. Taken together, these holdings will permit hospitals to injure competition in physician markets with impunity, erect barriers that will make it more difficult for physicians to open competing facilities and injure consumer welfare.

A. The Physician-Hospital Relationship Is Not Vertical, And Therefore Not Entitled To Deferential Antitrust Analysis.

The Third Circuit labeled the Information Restraints as "non-price vertical restraints," mistakenly concluding that any arrangement between a doctor and a hospital is vertical. App at 41. Based on that classification, the Third Circuit then held that the Information Restraints were reviewable only under the full-blown rule of reason. *Id.* That required Plaintiffs to prove that the Hospital possessed market power. The district court rejected Plaintiffs' geographic market (partially through its own *sua sponte* "Mapquest" investigation) and then defined its own market in which the Hospital possessed a market share of approximately 45%. App at 130. Petitioners are not challenging this here (or even the Third Circuit's unprecedented bright-line rule that a firm lacks market power, as a matter of law, if its market share is below 50%). App at 47. Rather, the district court should never have reached that point because it was error to label the relationship between hospitals and physicians as vertical in the first place. Vertical restraints are "those imposed by agreement between firms at different levels of distribution . . . " of a product, such as the relationship between a manufacturer and its distributors. *Business Electronics Corp. v. Sharp*

Electronics, Corp., 485 U.S. 717, 730 (1988). Even the "Chicago School's" analysis of vertical restraints is based on "a marketing system in which the manufacturer places restrictions on competition among the distributors or dealers that provide goods to lower links in the chain of distribution." Posner, *The Next Step in the Antitrust Treatment of Restricted Distribution: Per Se Legality*, 48 U. Chi. L. Rev. 6 (1981). The case on which the Third Circuit relies, *Orson, Inc. v. Miramax Film Corp.*, 79 F.3d 1358 (3d Cir. 1996) concerned the relationship between a distributor and a retailer of films, an example of a truly vertical relationship.

The relationship between a hospital and a physician, in contrast, is typically not vertical, and surely was not vertical here. The Hospital competed in a facility market while Dr. Gordon as a surgeon competed in a physician service market. App at 104 n.24. These markets were not related vertically but were complementary markets: patients needing cataract surgery also need an operating room and a physician. *Id.* Dr. Gordon was not an agent of the Hospital, and he neither bought nor resold any goods or services of the Hospital. Instead, Dr. Gordon (as a surgeon) offered patients a completely different service that the Hospital as a facility did not provide. *See, Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984) (although hospital and physician services are related, they are separate, complementary products).

The fundamental error committed by the Third Circuit was to apply the "vertical" label without regard for the relationship between the contract parties or the economic effect of the restraint. *See, Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 58-59 (1977). Non-price vertical restraints are judged under the lenient rule of reason because it is likely that a manufacturer has procompetitive reasons to restrain competition among resellers of its products and the risk of genuinely anticompetitive effects

is low. *Business Electronics Corp. v. Sharp Electronics, Corp.*, 485 U.S. 717, 724-30 (1988); Easterbrook, *Vertical Restraints and the Rule of Reason*, 53 Antitrust L.J. 135, 147-52 (1984). The manufacturer's primary interest is to distribute its products efficiently and, thus, to make them more competitive against competing products. Under such conditions the "manufacturer shares with the consumer the desire to have distribution done at the lowest possible cost consistent with effectiveness." Robert H. Bork, The Antitrust Paradox 290 (1978).

A hospital's interests when dealing with its medical staff, however, often are not aligned with consumers' interests. *See, e.g., Potters Medical Center v. City Hosp. Ass'n*, 800 F.2d 568, 575-77 (6th Cir. 1986) (hospital excludes competent physicians to restrain competition from competing facility). Physician services and facility services are separate, and may be chosen separately or together. For example, if Dr. Gordon told a patient about the comparative benefits of phaco over ECCE (used by Dr. Nancollas), the patient could prefer phaco but still prefer not to use Dr. Gordon's services. The patient would then use a different physician and must travel to a different facility (because, at the Hospital, only Dr. Gordon used phaco). *See, also*, Health Law 811.

Moreover, hospitals are not neutral with respect to the physician choices patients make. Hospitals and physicians bill clients separately for the services they provide. Hospitals charge for the use of operating rooms, equipment and supplies. A physician charges patients separately for his or her services. An efficient physician may use fewer hospital services than a less efficient physician. That was true here, where Dr. Gordon's phaco method used less operating room time, less equipment, and less anesthesia. App at 58-62. In such a case, the hospital has an interest in having patients seen by the less efficient physician whose patients use the hospital's services more intensely.

Information restraints that limit the ability of the more efficient physician to attract patients may benefit the hospital by causing consumers to make inefficient choices due to a lack of information about treatment options. The Federal Trade Commission and Department of Justice recognized recently in their joint report on competition in health care that providing more efficient care to patients may cause health care providers to lose money. *Improving Health Care*, Report By The Federal Trade Commission and the Department of Justice (September, 2004) ("*Improving Health Care Report*"), Ch. 1, at 25-26. This does not happen in a truly vertical relationship, where a manufacturer understands that inefficient distribution practices will impede the distribution of its product and hurt its ability to compete with other manufacturers.

Finally, hospitals may impose restraints on physician competition not out of a concern for patients but as an effort to enforce collusive conduct by physicians. Hospitals may restrain physician competition in order to increase admissions by attracting physicians who want to limit the competition they face. This is not a trivial concern given the long history of provider-created restraints on competition. *See, Improving Health Care Report*, Ch. 1 at 36; Sage, Hyman and Greenburg, *Why Competition Law Matters To Health Care Quality*, 22 Health Affairs 31, 34-5 (2003).

It was, therefore, unwarranted for the Third Circuit simply to assume that the Information Restraints were non-price vertical restraints. The Third Circuit did not, and could not, explain why a hospital should have the broad authority to control physician competition in the same manner that manufacturers are permitted to control the distribution of their products.

The Third Circuit's application of the "vertical" label here demonstrates the danger of relying on labels in antitrust analysis. The dichotomy between vertical and horizontal relationships grew out of the related dichotomy

that used to exist between *per se* treatment and the rule of reason. That distinction is no longer so clear. Judge Ginsburg, writing for the D.C. Circuit in the "Three Tenors" case, explained:

> Since [*National Society of Professional Engineers v. Federal Trade Comm'n*, 435 U.S. 679 (1978)] the Supreme Court has steadily moved away from the dichotomous approach – under which every restraint of trade is either unlawful *per se*, and hence not susceptible to a procompetitive justification, or subject to a full-blown rule-of-reason analysis – toward one in which the extent of the inquiry is tailored to the suspect conduct in each particular case.

Polygram Holding, Inc. v. F.T.C., 416 F.3d 29, 34 (D.C. Cir. 2005). A so-called "quick look" analysis – between *per se* illegality and a condemnation only after a full rule of reason trial – is not a distinct third category. Rather, as Judge Ginsburg wrote, "the Court has [not] moved from a dichotomy to a trichotomy, [but instead] has backed away from any reliance upon fixed categories and toward a continuum." *Id.*, citing *California Dental Ass'n v. F.T.C.*, 526 U.S. 756, 779 (1999). It is to be "an enquiry meet for the case." *California Dental*, 526 U.S. at 781.

The horizontal/vertical dichotomy was a shorthand device for selecting the level of review a restraint would receive. When the *per se*/rule of reason dichotomy broke down, the horizontal/vertical dichotomy became a poor device for selecting the level of review a restraint should receive.

Accordingly, instead of allowing a label to define the level of antitrust scrutiny, the anticompetitive potential and the plausibility of procompetitive benefits should determine the appropriate level of antitrust scrutiny:

> Although many vertical arrangements have characteristics distinguishing them in important ways from the bulk of horizontal arrangements, horizontal and vertical restraints do not always threaten competition in different ways, or call for different analysis. Although often helpful or convenient, the horizontal-vertical distinction need not be absolute. It is relevant only insofar as it helps identify competitive effects.

Areeda and Hovenkamp, Antitrust Law, ¶1503, p.348 (Aspen 2nd ed. 2002-2005) ("Antitrust Law"). The Third Circuit's blind categorization, without regard to actual competitive effects, runs counter to this Court's repeated and growing directive. This case demonstrates why the Court needs to give direction to the lower courts.

B. The Relationship Between A Hospital And A Physician Is Horizontal Where The Physician Has Taken Substantial Steps To Open A Surgical Facility.

Regardless of whether the physician-hospital relationship may generally be viewed as vertical, it was horizontal here. In 1996, when the Hospital and Dr. Gordon entered into the Information Restraints, Dr. Gordon had taken substantial steps to open a surgery center in competition with the Hospital. App at 67-70, and 80-82. The contract was presented to Dr. Gordon on September 30, 1996, and was effective on November 14, 1996. App at 11. Well before that date, the Hospital viewed Dr. Gordon as a competitor in the facility market. In late 1995, the Hospital learned of Dr. Gordon's threat to open a competing surgi-center. App at 15. In 1996, before the Hospital and Dr. Gordon agreed to the Information Restraints, Dr. Gordon, the Hospital and Dr. Everhart all filed dueling Certificate of Need applications. App at 81. Dr. Everhart and the Hospital filed their oppositions to Dr.

Gordon's CON on October 1, 1996, the day after they demanded he sign the Information Restraints. Consequently, it is undeniable that Dr. Gordon's facility was a potential competitor of the Hospital at the time the Hospital imposed the Information Restraints.

The Third Circuit nonetheless concluded that the Information Restraints were vertical restraints. The Third Circuit first held that all agreements between a hospital and a physician are vertical restraints and then held that this was "especially true" here because:

> Gordon and the Hospital were not competitors in the relevant market in November [1996][2] when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later.

App at 41. Under the Third Circuit's holding, agreements restraining competition are vertical until the new entrant actually opens his facility. Presumably, if this case had involved a commercial setting, the court would have viewed the Information Restraints as horizontal: "Horizontal restraints consist of restrictions established by agreements among actual *or potential competitors*." ABA Antitrust Section, Antitrust Law Developments 79 (5th ed. 2002) (emphasis added); *Palmer v. BRG of Georgia*, 498 U.S. 46 (1990) (although defendants had never competed in the same market, their market allocation agreement was *per se* illegal); National Committee to Study the Antitrust Laws 26 (Attorney General 1955) ("Where actual or potential competitors agree not to compete in specified territories, or for specified customers, the consequence is to reduce the

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[2] The Third Circuit's opinion contains a typographical error at this point, dating the Conditions of Reappointment in 1995; elsewhere in the opinions below, it is clear that the contract was accepted by Dr. Gordon in October 1996, and signed by the parties in November 1996. App at 11; App at 67-68.

number of sellers in each affected market"). An agreement by two firms to remain on opposite sides of the Mississippi River is just as illegal whether it is an agreement to retreat from existing competition, or one not to compete in the first place.

The Third Circuit, in two places, ignored the importance of potential competition: it held that the contract between the Hospital and Dr. Gordon was not horizontal (App at 41), and trivialized the express market allocation agreement between the Hospital and Dr. Everhart (App at 50-51). This is a pernicious rule of law that undermines antitrust enforcement.

Suppose, for example, that the Hospital required each doctor on its staff, as a condition of hospital privileges, to agree not to open a facility in competition with the Hospital. Under the Third Circuit's holding, that agreement is presumptively lawful the day before the facility opened, but possibly *per se* unlawful the next day. Agreements to restrain potential competition are likely more common and more difficult to deter than agreements between existing competitors: the deterred competitor has less invested in the new enterprise. A rule of law that permits restraints among potential, but not yet current, competitors makes no economic sense and would give hospitals a perverse incentive to impose such agreements on physicians before competition begins.

C. A Restraint On Truthful Competitive Information Is Anticompetitive.

There are compelling reasons to condemn the Information Restraints as plainly anticompetitive. The district court found that "the most meaningful competition among surgeons is on the basis of quality and patient preference [for surgical method or physician]." App at 108. The importance of physician competition was explained by the FTC and Antitrust Division of the Department of Justice in their 2004 *Improving Health Care Report*. The Information Restraints restrained that competition.

The comparative information barred by the Information Restraints was also the output of a service provided by Dr. Gordon to patients. Advice and information about different treatment options is a service physicians give to their patients. As one prominent commentator explained, even advertising may be "output" of information: "[t]ruthful advertising is an important output of any firm . . . As such, an agreement among competitors . . . that they will restrict the content of their advertising even if it is truthful is ordinarily illegal per se." XII Antitrust Law ¶2023b2 (2005). That is even more true for direct communications between a physician and patient where patients look predominantly to physicians for advice. Health Law, 412-13. *See, also,* XI Antitrust Law ¶1912f, p.330. Indeed, patients are dependent upon physicians for information affecting their well-being, and physicians have a corresponding responsibility to provide that information. *See, Canterbury v. Spence*, 464 F.2d 772, 782 (D.C. Cir. 1972). This Court acknowledged the same point in *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 459 (1986), holding that an agreement between dentists to limit the information they provided to consumers (who in that case were the insurance companies paying for the service) was an output restraint. *See*, XI Antitrust Law, ¶1911(b), p.298.

It was erroneous for the Third Circuit to apply a deferential standard of review to a direct limitation on output. *See*, *National Collegiate Athletic Ass'n v. Board of Regents of the University of Oklahoma*, 468 U.S. 85 (1984); *Mariana v. Fisher*, 338 F.3d 189, 196 (3d Cir. 2003); *Chicago Professional Sports, Ltd. Partnership v. National Basketball Ass'n*, 961 F.2d 667, 675-76 (7th Cir. 1992) ("unless there are sound justifications for an output restraint, the court condemns the practice without ado").

Moreover, regardless of whether the Information Restraints limited output, they were direct limitations on physician competition and, thus, are anticompetitive. As the FTC and Antitrust Division stated in the *Improving Health Care Report*:

> Information regarding quality allows consumers to make their own determinations of how best to balance those attributes that are important to them, obtain value for their money, and drive improvements throughout the system. If consumers are poorly informed about quality, providers may offer an inefficiently low level of quality.

Improving Health Care Report, Ch. 1, at 17. The district court found that information provided by physicians is critical to effective competition in health care markets: "communication of truthful information to patients and other physicians is an important part of competition in the field of medicine." App at 140. As this Court stated in *Virginia State Board of Pharmacy v. Virginia Citizens Council*, 425 U.S. 748, 765 (1976):

> Advertising, however tasteless and excessive it sometimes may seem, is nonetheless dissemination of information as to who is producing and selling what product, for what reason, and at what price. So long as we preserve a predominantly free enterprise economy, the allocation of our resources in large measure will be made through numerous private economic decisions. It is a matter of public interest that those decisions, in the aggregate, be intelligent and well informed.

Information restraints are particularly harmful to consumers in health care markets. The information asymmetries that exist between physicians and patients highlight the need for more, not less, disclosure to patients. "A lack of

good information . . . hampers consumers' ability to evaluate the quality of the health care they receive." *Improving Health Care Report*, Executive Summary, at 5. The Report explained:

> The public has access to better information about the price and quality of automobiles than it does about most health care services. It is difficult to get good information about the price and quality of health care goods. . . .

Id. at 6.

The *Improving Health Care Report* analyzes alternative strategies to improve health care markets, but concludes that "[f]or such strategies to work, however, consumers will need reliable and understandable information about the prices and quality of the services among which they must choose." *Improving Health Care Report*, at 18. Put differently, "good information is a necessary building block both for consumer empowerment and enhanced health." *Improving Health Care Report*, at 20, relying on George S. Stigler, *The Economics of Information*, 69 J. Pol. Econ. 213, 220 (1961). Information restraints, therefore, will insulate inefficient practices, lead to higher costs for physician services, and result in lower quality care.

The facially anticompetitive nature of the Information Restraints is not offset by any legitimate procompetitive benefit. The Third Circuit did not even consider whether they produced any procompetitive effect. The district court believed that the Information Restraints would permit the Hospital to run more efficiently by "protect[ing] the internal cohesiveness" of physicians practicing at the Hospital. App at 147-49. The district court's rationale is nothing more than a claim that competition will harm consumers. This is not a permissible procompetititve justification. *National Soc. of Professional Engineers v. U.S.*, 435 U.S.

679, 693-95 (1978). This is particularly true because the Information Restraints did not regulate the time or manner of Dr. Gordon's communications, and were not limited to Dr. Gordon's conduct while in the Hospital.

Short of the *per se* offenses, it is difficult to imagine a more anticompetitive agreement. The Information Restraints would prevent Dr. Gordon from differentiating the surgical care he would provide at his facility from the care Dr. Nancollas would provide at the Hospital. A ban on Dr. Gordon's competitive comparative communications "serves to perpetuate the market position of established participants." *Bates v. State Bar of Arizona*, 433 U.S. 350, 378 (1977).

This Court has addressed information restraints in health care twice before. First, in *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447 (1986), a unanimous Court condemned a restraint limiting information, without a full inquiry into market power. Thirteen years later, the Court was divided five-to-four over the level of proof needed to condemn a prohibition on "false or misleading" statements. *California Dental Ass'n v. F.T.C.*, 526 U.S. 756 (1999). The majority would not condemn the restraints under the most truncated of quick looks, but required a further analysis (although still not a full-blown rule of reason review) because it was not clear that the restraints had a net anticompetitive effect. There, the Court considered the possible procompetitive effect of "preventing misleading or false claims that distort the market." *Id.* at 771. Those restraints required additional information which the Court found could make communications "exact, accurate and verifiable." *Id.* at 775. Consequently, on that record, the Court found the restraints could have net procompetitive effects.

Here, the Information Restraints were not designed or created to prevent the dissemination of false and misleading information, and did not require physicians to provide more

information to consumers. They were naked restraints on comparative information with no countervailing competitive benefit. Indeed, the Third Circuit did not find, or even consider, any procompetitive effect. Consequently, this is the case, contemplated by both the majority opinion and by Justice Breyer's dissent, of a restraint for which no full-blown market analysis was needed. *Id.* at 775 n.12.

CONCLUSION

This case has substantial national importance – importance to protecting competition in health care, importance to establishing antitrust jurisprudence based on economics rather than labels, and importance to the free exchange of competitive information. The Third Circuit's decision, if allowed to stand, undermines all of those fundamental principles. Consequently, Petitioners respectfully ask this Court to issue a writ of *certiorari* to review the judgment below.

Respectfully submitted,

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Dated: February 6, 2006

423 F.3d 184

United States Court of Appeals,
Third Circuit.

Alan D. GORDON, M.D.; Alan D. Gordon, M.D., P.C., a corporation; Mifflin County Community Surgical Center, a corporation, Appellants

v.

LEWISTOWN HOSPITAL.

No. 03-3370.

Argued Sept. 14, 2004.
Sept. 12, 2005.

Steven B. Varick (Argued), Henry S. Allen, Jr., Holland & Knight, Chicago, IL, George M. Sanders, Audrey L. Gaynor & Associates, Chicago, IL, for Appellants.

Jonathan B. Sprague (Argued), Post & Schnell, Philadelphia, PA, Susan M. Lapenta, Horty, Springer & Mattern, Pittsburgh, PA, for Appellee.

Robert B. Hoffman, Wolf, Block, Schorr & Solis-Cohen, Harrisburg, PA, for Amicus-Appellant Pennsylvania Medical Society.

David E. Loder (Argued), Duane Morris, Philadelphia, PA, for Amicus-Appellee the Hospital & Healthsystem Association of Pennsylvania.

Before ALITO, AMBRO and FISHER, Circuit Judges.

OPINION OF THE COURT

FISHER, Circuit Judge.

This antitrust case arises from professional review actions undertaken by Lewistown Hospital (the "Hospital") to stem unprofessional conduct engaged in by Alan D.

Gordon, M.D. ("Gordon") that impacted adversely upon patient welfare. Gordon and two corporations of which he is the sole shareholder, Alan D. Gordon, M.D., P.C., and Mifflin County Community Surgical Center, Inc. ("MCCSC") (which operates an outpatient surgical center in Lewistown, Pennsylvania), asserted against the Hospital multiple violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2, seeking both money damages and injunctive relief. The District Court granted summary judgment in favor of the Hospital regarding the majority of Gordon's antitrust claims that require as one of their elements a concerted action or conspiracy, and found no genuine issue of material fact that would support an inference of concerted action or conspiracy. The District Court also determined that, pursuant to the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11101-11152, the Hospital was entitled to immunity from money damages regarding the professional review actions at issue.[1] Thereafter, the District Court conducted a non-jury trial and entered judgment in favor of the Hospital on the few remaining antitrust claims that sought injunctive relief. Gordon raises multiple issues in this appeal implicating both the summary judgment and post-trial rulings of the District Court. We will affirm the comprehensive rulings of the

[1] The immunity provided by the HCQIA for persons engaging in the peer review process is limited to damages liability. 42 U.S.C. § 11111(a). Disciplined physicians may still maintain actions for injunctive or declaratory relief. *See Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030-31 (4th Cir.1994) (detailing HCQIA legislative history regarding scope of immunity provided to individuals engaging in the peer review process).

District Court[2] that resulted in judgment for the Hospital as to all claims.

I. Facts

A. The Hospital

The Hospital, a general medical and surgical facility, is the only hospital serving Mifflin and Juniata counties in Pennsylvania. It provides primary and secondary acute inpatient care in addition to providing outpatient surgery through its outpatient surgery center. The Hospital does not employ any physicians, but instead grants staff privileges to physicians who practice there. The physicians granted staff privileges comprise the Medical-Dental Staff of the Hospital. A physician must be a member of the Medical-Dental Staff to practice at the Hospital. The Hospital's Credentialing Policy, adopted in 1991 and revised in 1997, sets minimum professional requirements for physicians practicing at its site.

The Medical-Dental Staff engages in a peer review process through its Credentials Committee. The Credentials Committee makes recommendations to the Hospital Board of Trustees, guided by the Hospital's Credentialing Policy, regarding whether particular physicians meet the minimum professional requirements to practice at the Hospital both as to their admission to and renewal of

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[2] The District Court performed extensive analysis of the parties' claims both at summary judgment and in its post-trial findings of fact and conclusions of law set forth respectively at *Gordon v. Lewistown Hospital*, No. CV-99-1100, 2001 WL 34373013 (M.D.Pa. May 21, 2001), and *Gordon v. Lewistown Hospital*, 272 F.Supp.2d 393 (M.D.Pa.2003). Consequently, this opinion sets forth only those facts necessary to inform our analysis.

Medical-Dental Staff membership. The Credentialing Policy states in part that "[a]ppointment to the medical staff is a privilege which should be extended only to professionally competent individuals continuing to meet the qualifications, standards and requirements set forth in this policy." It also specifies that to qualify for staff appointment, a physician must be able to work harmoniously with others sufficiently to convince the hospital that all patients treated by him will receive quality care and that the hospital and its medical staff will be able to operate in an orderly manner. The Policy further states that recommendations for reappointment shall in part be based upon the appointee's "behavior in the hospital, cooperation with medical staff and hospital personnel as it relates to patient care or the orderly operation of the hospital, and general attitude towards patients, the hospital and its personnel."

B. Gordon, Nancollas, and Their Respective Cataract Procedures

Gordon is an ophthalmologist first appointed to the Hospital's Medical-Dental Staff in 1980. Gordon and Dr. Paul Nancollas ("Nancollas"), an employee of Geisinger Medical Group-Lewistown ("Geisinger"),[3] who also was a member of the Medical-Dental Staff, were the only two ophthalmologists practicing at the Hospital. During the relevant period, the two employed different techniques in

[3] Geisinger provides both physician services and a health insurance plan. The health insurance plan is a closed plan, meaning that reimbursement of charges that patients incur will only be made if a Geisinger physician treats the patient. Gordon is not a Geisinger physician and has been denied admission to Geisinger's medical panel despite his attempts to obtain such status.

cataract surgery. Gordon's comments to patients regarding those differences and Nancollas's skills are at the heart of Gordon's antitrust claims.

Gordon performed cataract surgery using the phacoemulsification ("Phaco") procedure. The Phaco procedure involved making only a small incision in the cornea (which prevented bleeding) and used only topical anesthesia. Because the Phaco procedure led to a rapid improvement in vision, patients undergoing this procedure generally recovered in two (2) weeks. Gordon alleged that his Phaco procedure had fewer risks, took less time and cost 50% less than the extracapsular extraction ("ECCE") surgical technique employed by Nancollas. The ECCE procedure involved a larger incision and use of sutures. In addition, the ECCE procedure required that an anesthetic be injected into the back of the eye where the physician cannot see the end of the needle, risking damage to the eye and nervous system. Given the pain caused by the ECCE procedure, Nancollas also used a "sleep dose" of general anesthesia. Recovery from this surgery could extend up to three (3) months.[4]

Between 1993 and 1995, Gordon and Nancollas both placed various newspaper ads regarding their respective surgical practices in the Lewistown Sentinel in addition to other publications circulated in Mifflin and Juniata counties. In 1993, an ad (placed by Geisinger on Nancollas's behalf) indicated that Nancollas performed "modern cataract extraction" although at the time he still used the ECCE procedure. In response to what he perceived as false

[4] We note that Nancollas has since switched to the Phaco procedure favored by Gordon.

advertising, Gordon placed an ad in the Lewistown Sentinel comparing himself to Nancollas and urged readers to call the Hospital for information comparing the complication rates of their respective surgical outcomes. Although the Hospital informed Gordon of its belief that the release of such information was unlawful, and requested that he not suggest the release of such information in future advertisements, no disciplinary action arose from the ad. However, Gordon's subsequent ad of September 15, 1995, compared the two procedures, was critical of the "Geisinger ophthamologist" and indicated that all of the anesthesiologists at the Hospital preferred Gordon's anesthetic technique to that performed by Geisinger. Both Geisinger and Nancollas complained to the Hospital regarding this ad. The complaint was forwarded by the Hospital to the Credentials Committee because Gordon's ad indicated preferences of Hospital anesthesiologists. The Hospital took no disciplinary action against Gordon for this second ad, taking the position that it involved parties external to the Hospital, but indicated to Gordon its concern regarding the adversarial and unprofessional tone of Gordon's ad.

In 1995, however, Gordon contacted Nancollas's patients and made disparaging comments about Nancollas. In June 1997, Gordon again disparaged Nancollas's skills to a patient and sent a letter questioning Nancollas's skills to more than thirty people, including the entire Hospital Board. The crux of Gordon's claims here concern the Hospital's response to the 1995 and 1997 incidents culminating in the forty-five day suspension and subsequent revocation for a period of five years of Gordon's

Medical-Dental Staff privileges, both of which are discussed in the following section.[5]

C. Gordon's Conduct and Its Impact Upon His Medical-Dental Staff Privileges

1. The Suspension of Gordon's Medical-Dental Staff Privileges

In 1995, the Hospital received complaints from elderly patients who related that Gordon had telephoned them and made disparaging comments about Nancollas, with whom they were then treating. Hospital counsel twice wrote to Gordon's counsel warning that any additional complaints of this nature would trigger an investigation of Gordon's conduct. Despite this, Gordon called additional patients complaining about their decision to use Nancollas. By November of 1995, Gordon's harassing telephone calls to patients were addressed by the Hospital Credentials Committee, which determined that Gordon should be suspended for forty-five days and that his reappointment application should be postponed until after he had served the suspension. Gordon requested a hearing and was represented by counsel. Prior to the hearing, the Hospital

[5] To provide context, the Hospital chronicled a long history of disciplinary action regarding Gordon's professional behavior, not his competence. The details regarding these actions are set forth in the District Court opinions. These prior incidents, beginning in 1985, pertained to Gordon's disruptive behavior in using loud and profane language in public areas of the Hospital, verbally attacking other physicians within the Intensive Care Unit, yelling at a nurse who had witnessed his disruptive behavior, and telephoning a patient at her home regarding her decision to treat with another ophthalmologist. In 1992, Gordon verbally attacked a nurse in the Hospital's emergency department and received a 28-day suspension. *See Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa.Cmwlth.1998).

received additional complaints regarding Gordon's conduct. As a result, Gordon was summarily suspended on April 19, 1996, pending completion of the hearing and any resultant appeals regarding the forty-five day suspension.

At the conclusion of a three-day hearing, the forty-five day suspension was upheld. The Hearing Officer found that: (1) Gordon precipitated a confrontation involving Geisinger between himself and Dr. Quereshi (a Geisinger physician) on June 19, 1995, in the presence of a patient; (2) the confrontation and its effects were "unacceptable and disruptive"; and (3) Gordon's concerns about Geisinger and medical economics did not excuse such conduct. The Hearing Officer also found that Gordon had expressed himself to a nurse in an unacceptable manner when he stated that she "didn't give a damn about the patients," "is a trouble maker and always has been" and that "you are all assholes." The Hearing Officer concluded that whether Gordon's concerns were real or perceived, he addressed them inappropriately. At the hearing, there also was testimony regarding Gordon's telephone calls to Nancollas's cataract patients during the period of June 1994 to April 1995, some of which were made the night before the patients were to undergo cataract surgery. Although Gordon recognized that his calls could increase patient anxiety, he nonetheless placed the calls to warn the patients about Nancollas. The Hearing Officer concluded that the calls showed extremely poor judgment and cruelty towards patients. Gordon never appealed the Hearing Officer's decision to the Hospital's Appeal Review Panel.

2. The Revocation of Gordon's Medical-Dental Staff Privileges

During this period, Gordon's application for reappointment to the Medical-Dental Staff for the period of February 1, 1995 to January 31, 1997, was pending before the Credentials Committee. In light of the events to date, the Credentials Committee considered denying the application. But instead, it gave Gordon the opportunity to provide assurances that he understood the inappropriateness of his past conduct and to vow to conduct himself in the future in accordance with standards defined by the Credentials Committee and with all Hospital and Medical-Dental Staff bylaws. Specifically, on August 2, 1996, Dr. Charles Everhart, Chairman of the Credentials Committee, forwarded a letter to Gordon stating in part:

> The Credentials Committee has a very long history of dealing with problems created by your behavior and of imposing conditions and discipline in an effort to make you understand that your behavior cannot continue. A vastly disproportionate share of the Credentials Committee's time and of the Hospital's resources have been devoted to problems created by you. This is notice to you that those extensive efforts on your behalf are over. You will not be recommended for reappointment unless the Credentials Committee receives from you, absolute, credible assurances that you understand that your behavior has been inappropriate and that, in the future, you will consistently conduct yourself strictly in accordance with [the] standards outlined in this letter and with all hospital and medical staff bylaws and policies.

On August 14, 1996, Gordon agreed to adhere to those requirements in a letter to Everhart stating in part:

> I will use the administrative channels to register complaints or concerns about poorly functioning equipment or about others practicing at the hospital or assisting me.
>
> * * *
>
> I find that my phone calls to patients were counterproductive and I stopped making these calls in late 1995. Although I feel that patients ought to be informed of their situation, I have not called patients for sometime nor is it my intention to call or otherwise attempt to communicate with the patients of any other ophthalmologist for the purpose of commenting on that physician's training, skill or competency or the procedure performed by such physician.

By September 5, 1996, however, Gordon engaged in a shouting match in the presence of patients and nursing personnel with a physician who had referred a patient to Nancollas. Consequently, the Credentials Committee provided Gordon one last opportunity to explain his conduct as part of an investigation.

a. The Conditions of Gordon's Reappointment

On September 30, 1996, the Credentials Committee offered Gordon conditional reappointment if he agreed to seventeen "Conditions of Reappointment" ("Conditions"), the relevant portions of which follow:

> (2) You must use appropriate administrative channels to register any complaint or concern

that you might have about others practicing at the Hospital. Specifically, any complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Hospital, with a copy to the President of the Hospital. Any complaint or concern about any nursing personnel shall be reported in writing to that individual's supervisor, with a copy to the President of the Hospital. Any other complaint or concern about scheduling, equipment or any other matter must be in writing directed to the President of the Hospital; and

(3) You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician. Furthermore, other than in response to a specific question or for the purpose of a referral, you shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

After consulting with counsel, Gordon indicated on October 10, 1996, that he would accept the Conditions. On November 11, 1996, the Chairman of the Hospital Board of Trustees, Robert Postal, notified Gordon of his reappointment to the Medical-Dental Staff subject to his strict adherence to the Conditions. On November 14, 1996, Gordon provided his written agreement to be bound by the Conditions. He now contends that these Conditions constitute an unreasonable restraint on trade. But as discussed

infra, we find that they were reasonable in light of Gordon's conduct and do not impermissibly restrain trade in any relevant antitrust market.[6]

b. Gordon's Breach of the Conditions of Reappointment

By June of 1997, Gordon had twice breached the Conditions causing a second revocation of his privileges. First, on a Sunday afternoon, he called the home of Mrs. Seecora, a then eighty-two year old former patient. Mrs. Seecora, who had since enrolled in the Geisinger Health Insurance Plan, was at that time a patient of Nancollas.[7] During that call, even after Mrs. Seecora stated that she was treating with Nancollas (which should have triggered Condition 3), Gordon proceeded to discuss with her the differences in procedures performed by each physician (despite the fact that Nancollas had already removed one of her cataracts); conveyed his personal animus for Nancollas, indicating that Nancollas was "just learning"; listed the unnecessary risks that she faced in having Nancollas remove her cataract; and told her that she had been

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[6] We note, as the District Court found, that even once the Conditions were imposed, Gordon placed at least two ads in the Lewistown Sentinel with one of the ads pointing out the increased risks associated with the technique employed by the "Geisinger physician." The Hospital took no disciplinary action regarding these activities.

[7] Gordon treated Mrs. Seecora three (3) times from July 22, 1994 to September 1994. On October 18, 1995, his office contacted Mrs. Seecora as a "follow-up" to her last appointment of September 1994. On January 4, 1996, Gordon's office sent a re-call card to her. On August 26, 1996, his office telephoned her, at which time she indicated she was doing well and seeing her eye doctor. When Gordon's office contacted her again in April 1997, however, she declined to make an appointment, indicating that she was taking care of her condition.

misled and uninformed because Nancollas "sometimes doesn't tell the whole story." Mrs. Seecora's daughter reported the incident to the Hospital President's office conveying that Gordon's unprofessional conduct had intimidated and harassed her mother.

Gordon also breached the Conditions when he mailed a letter dated June 4, 1997, to over thirty people, including the entire Hospital Board, the Hospital Credentials Committee, and the Hospital's Administration, containing a five-paragraph critique of Nancollas's surgical method. The letter itself indicated that it was "sent on the request of the administration who notified [him] that if [he] did have concerns [concerning potential risks to patients], [he] should put them in writing rather than just verbally discussing them with the administration." But per the Conditions of his reappointment, Gordon should have directed the letter to the President of the Medical Staff or the Chairperson of the Credentials Committee with a copy to the President of the Hospital. Despite this procedural shortcoming, because Gordon had raised a concern regarding the quality of care at the Hospital, the Credentials Committee initiated a quality study of Nancollas's procedure.[8] That investigation ultimately concluded that Nancollas's procedure fell within the applicable standard of care.

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[8] Surprisingly, given the history of Gordon's conduct, this was the first written complaint Gordon made regarding Nancollas's competency. Gordon critiqued Nancollas's surgical method, including: (1) the type of anesthesia used; (2) the longer duration of the procedure; (3) the length of the incision; (4) stroke risks associated with the incision and manner of administering anesthesia; and (5) unnecessary risks associated with Nancollas's use of certain equipment.

c. The Decision to Revoke Gordon's Medical-Dental Staff Privileges

In the wake of this conduct, Gordon met with the Credentials Committee at their request on July 17, 1997. The next day, the Credentials Committee Chair informed Gordon that the Committee determined that he violated the Conditions of his reappointment and that he would be excluded from the Hospital after July 23, 1997. Gordon pursued a hearing on the recommendation, which was held on August 22, 1997. At the hearing, Everhart testified regarding the Hospital's ongoing concern about Gordon's unprofessional conduct and its potential threat to patient care. In addition, both Mrs. Seecora and her daughter conveyed that Gordon's Sunday afternoon telephone call to the then eighty-two year old was unprofessional, inappropriate, intimidating, and harassing. On September 25, 1997, the Hearing Officer upheld the revocation of Gordon's appointment and clinical privileges, concluding in part that "the Hospital could not draft a condition . . . that would protect the Hospital and its patients from Gordon's poor judgment." Gordon appealed the decision, but the Appellate Review Panel, in its November 24, 1997 Recommendation and Report, affirmed in part because Gordon continued to harass, intimidate and upset elderly and vulnerable hospital patients. On November 25, 1997, the Board informed Gordon that it had adopted the recommendation to revoke his privileges.

D. The Hospital's Alleged Predatory Tactics

Gordon also contends that the Chairman of the Credentials Committee, Everhart, conspired with the Hospital to revoke Gordon's Medical-Dental Staff privileges in order to placate Geisinger's concern regarding his

anti-Nancollas ad campaign and to prevent him from opening MCCSC as an independent surgical center.

1. Everhart's Surgical Center

In 1995, the only surgical facilities in Mifflin and Juniata counties were the Hospital and an outpatient center attached via a corridor to the Hospital that was owned by Everhart. Everhart had a written market allocation agreement with the Hospital, prohibiting each from providing services that the other provided. That center possessed a then-State mandated Certificate of Need ("CON") for the performance of endoscopic procedures.[9] Apparently, in 1995, Gordon requested and was denied permission to operate out of Everhart's facility because ophthalmologic surgery did not conform to the CON among other reasons. *See Gordon,* 272 F.Supp.2d at 410. Gordon threatened to open his own facility, which Everhart reported to the Hospital. In fact, both the Hospital and Gordon pursued a CON to open an outpatient surgical facility. But Everhart never competed with Gordon either in the outpatient surgical services market or the physician services market. Gordon contends that it was only after this threat to competition that the Hospital dredged up written patient complaints regarding the calls made by Gordon to Nancollas's patients. He further contends that Everhart and the Hospital worked in tandem to prevent Gordon's competitive threat.

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[9] Until 1996, Pennsylvania law required that prior to opening an outpatient surgical center, the Commonwealth must issue a CON indicating that an unfulfilled need existed for additional medical facilities services in the proposed facility's service area.

2. Geisinger

Gordon further contends that the revocation of his Medical-Dental Staff Privileges for his having commented upon Nancollas's cataract procedures to patients was precipitated not by his conduct, but rather as a result of the Hospital's economic relationship with Geisinger. In support of this, Gordon points to the 1995 expiration of Geisinger's lease for two-thirds (2/3) of the space in the Hospital's medical office building; Geisinger physicians' use of Hospital facilities; and its insurance plan's reimbursements comprising 16.9% of the Hospital's revenue. Gordon asserts that this economic dependence, coupled with Geisinger's prior request that the Hospital deal with Gordon's advertising against Nancollas, supports his theory of an antitrust conspiracy with respect to the Hospital's eventual suspension and subsequent revocation of his Medical-Dental Staff privileges. *See Gordon,* 272 F.Supp.2d at 409-411.

3. Discouraging Other Physicians from Practicing at MCCSC

In order to open MCCSC, Gordon required at least one anesthesiologist on staff. All anesthesiologists on the Hospital's Medical-Dental Staff were contractually precluded from practicing at any other facility. Consequently, Gordon sought the services of non-Hospital anesthesiologists to assist him at MCCSC. Gordon contends that the Hospital attempted to dissuade anesthesiologists who indicated their willingness to work for MCCSC from joining Gordon and MCCSC. Gordon also contends that the Hospital interfered in his relationship with an orthopedic surgeon who, although a member of the Hospital

Medical-Dental Staff, intended to perform surgery at MCCSC. *See Gordon,* 272 F.Supp.2d at 412-13.

II. Procedural History

A. Gordon's Complaint

In his June 25, 1999 Complaint subsequently amended on February 2, 2000,[10] Gordon asserted eight claims under the Sherman Act, 15 U.S.C. §§ 1-2, against the Hospital. He alleged five claims invoking Section 1 of the Sherman Act. 15 U.S.C. § 1. In Count I, he alleged that the Conditions governing his reappointment to the Medical-Dental Staff in 1996 constituted a contract in restraint of trade given that the Conditions prevented him from competing to retain or obtain business by providing information to patients regarding their surgical decisions and by foreclosing him from supplying services in the relevant physician ophthalmic service markets ("Conditions as restraint of trade"). Count II asserted that the Hospital illegally tied its outpatient cataract facility services to the purchase of ophthalmic services from a Geisinger physician, Nancollas ("illegal tying"). In Count IV, Gordon contended that the Hospital and Geisinger entered into a reciprocal arrangement whereby Geisinger leased space from the Hospital on condition that the Hospital procure substantially all of its physician specialty services (including ophthalmology) from Geisinger ("reciprocal

[10] We note that in addition to this action, Gordon mounted various challenges to the revocation of his privileges. Two court actions filed in Pennsylvania state courts were summarily dismissed and upheld on appeal. *Gordon v. Lewistown Hospital,* 729 A.2d 1284 (Pa.Cmwlth.1999) and *Gordon v. Lewistown Hospital,* No. 01071 HGB 1998, 1999 WL 627797 (Pa.Super.Ct. March 16, 1999).

dealing"). Count V asserted that the Hospital engaged in a group boycott to exclude Gordon from the outpatient cataract surgery market ("group boycott"). In Count VI, Gordon plead that the Hospital engaged in exclusive dealing ("exclusive dealing").

Gordon also asserted three (3) claims invoking Section 2 of the Sherman Act, 15 U.S.C. § 2. He alleged in Count III that the Hospital attempted to monopolize the market for outpatient cataract facility services in the Lewistown area since 1996 ("attempted monopolization of facility services") and in Counts VII and VIII that the Hospital conspired with Geisinger to monopolize, respectively, the outpatient facility services market and the physician inpatient, outpatient, and outpatient ophthalmic surgical services market ("conspiracy to monopolize markets").

B. The Summary Judgment Motions

The Hospital sought summary judgment on Gordon's antitrust claims alleging concerted activity or conspiracy. The claims implicated by the Hospital's summary judgment motion included: Count I (Conditions as restraint of trade), Count IV (reciprocal dealing), Count V (group boycott), Count VI (exclusive dealing) and Counts VII and VIII (conspiracy to monopolize markets). The Hospital argued that there was no genuine issue of material fact supporting an inference of the alleged concerted action or conspiracy. Gordon countered that the record contained ample evidence that the Hospital conspired with Geisinger and/or Robert Postal, Chairman of the Hospital Board of Trustees, to restrain his ability to provide patients with information regarding the respective surgical procedures employed by him as compared to Nancollas. The District

Court granted summary judgment on May 21, 2001, in favor of the Hospital on these Counts, concluding that Gordon had not presented any evidence from which a reasonable jury could find the existence of a conspiracy between the Hospital and Geisinger and/or Postal.

At the same time, the Hospital also moved for summary judgment on its affirmative defense that it possessed immunity from money damages liability under the HCQIA for its actions in suspending and subsequently revoking Gordon's Medical-Dental Staff privileges. The Hospital contended that those actions were "professional review actions" within the meaning of 42 U.S.C. § 11151(9), and thus gave rise to immunity from money damages. Gordon cross-moved for summary judgment on the Hospital's HCQIA immunity defense, asserting that: (1) the solicitation exception to the definition of professional review action applied, *see* 42 U.S.C. § 11151(9)(B) (exempting from HCQIA immunity an action by a professional review body that is primarily based on the "physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business"); (2) the revocation of Gordon's Medical-Dental Staff privileges did not relate to either his competence or professional conduct, *see* 42 U.S.C. § 11151(9); (3) the revocation of his Medical-Dental Staff privileges was not based on conduct that affects patient welfare, *see* 42 U.S.C. § 11151(9); and (4) that granting immunity would violate the purpose of the HCQIA by punishing a physician for criticizing incompetent competitors. He also argued alternatively that even if there was a professional review action, the requirements for obtaining HCQIA immunity set forth in 42 U.S.C. § 11112(a) were not met. The District Court determined that application of the solicitation exception turned on the

subjective intent of the physician engaging in the professional conduct at issue. As subjective intent was a disputed issue of fact, summary judgment was denied.

Gordon and MCCSC also moved for summary judgment as to Count I (Conditions as restraint of trade), asserting that analysis of the claim under the traditional rule of reason test was not necessary to find that the Conditions governing his reappointment to the Hospital Medical-Dental Staff violated the Sherman Act. Rather, he argued that the "quick look" approach applied. *See United States v. Brown Univ.*, 5 F.3d 658, 668-69 (3d Cir.1993). Applying instead the traditional rule of reason analysis to the claim, the District Court determined that Gordon and MCCSC failed to satisfy their initial burden of demonstrating that the Conditions resulted in anti-competitive effects in the relevant product and geographic markets. *Id.* The District Court concluded that there existed a genuine issue of material fact as to the scope of the relevant geographic market. *Gordon*, 2001 WL 34373013 at *11-12. Based on this determination, the District Court also denied the Hospital's motion for summary judgment as to Count II (illegal tying) and Count III (attempted monopolization of facility services), given that they also required definition of the relevant geographic market. *Id.* at *24-25.

In sum, upon entry of the District Court's May 21, 2001 Order, the only claims remaining for trial were Counts II (illegal tying) and III (attempted monopolization of facility services). But both parties filed motions for reconsideration of the May 21, 2001 Order resulting in the District Court's issuance of its August 15, 2001 order, modifying its prior ruling as to Count I (Conditions as restraint of trade) and HCQIA immunity. The District Court reinstated Count I, concluding that it had erred by

including that Count as a claim that could not be maintained in the absence of conspiracy, particularly since it alleged a "contract" violating the Sherman Act. The District Court also reconsidered its prior ruling on HCQIA immunity, concluding that it had misinterpreted the solicitation exception by focusing on the physician's subjective competitive intent when it should have focused on the basis for the Hospital's action. Consequently, the District Court granted the Hospital HCQIA immunity from damages regarding the 1996 suspension and 1997 revocation.

C. The Bench Trial

Between April 3 and 23, 2002, the District Court conducted a non-jury trial as to the antitrust claims that survived summary judgment. These included Counts I (Conditions as restraint of trade), II (illegal tying) and III (attempted monopolization of facility services), pursuant to which Gordon sought injunctive relief in the form of rescission of the Conditions and reinstatement of his Medical-Dental Staff privileges. On July 11, 2003, the District Court entered judgment for the Hospital as to all remaining claims after issuing extensive findings of facts and conclusions of laws.

D. Issues on Appeal

On appeal, Gordon challenges the District Court's grant of summary judgment in favor of the Hospital as to: (1) HCQIA immunity from money damages for the 1997 revocation[11] of Gordon's Medical-Dental Staff privileges

[11] Gordon does not challenge the application of HCQIA immunity to any damages arising from the 1996 suspension.

and (2) those of Gordon's antitrust claims which require a concerted action or conspiracy (i.e., Count IV (reciprocal dealing), Count V (group boycott), Count VI (exclusive dealing) and Counts VII and VIII (conspiracy to monopolize markets)). He also challenges the July 11, 2003 entry of judgment for the Hospital based upon the District Court's post-trial findings of fact and conclusions of law with respect to Count I (Conditions as restraint of trade), Count II (illegal tying), and Count III (attempted monopolization).[12]

For the reasons that follow, we will affirm the District Court.

III. Standards of Review

We have jurisdiction under 28 U.S.C. § 1291 to review the District Court's final order. We address Gordon's challenges consistent with their procedural development. We first will address the issues raised on appeal concerning the District Court's summary judgment rulings. *Gordon,* 2001 WL 34373013. Our review of the District Court's grant of summary judgment is plenary. *Mathews v. Lancaster General Hosp.,* 87 F.3d 624, 632 (3d Cir.1996).

Next, we will consider the challenges to the District Court's findings following the non-jury trial. *Gordon,* 272 F.Supp.2d 393. We review the District Court's factual

[12] In making its findings, the District Court determined that Gordon was not a credible witness regarding his conduct or the Hospital's reaction to it. The District Court also considered evidence that indicated Gordon's true motivation for this lawsuit – his desire to ruin the Hospital by dragging it through protracted and expensive litigation.

findings from the non-jury trial under a clearly erroneous standard, meaning that a finding is clearly erroneous if we are left with a definite and firm conviction that a mistake has been committed. *United States v. Igbonwa,* 120 F.3d 437, 440 (3d Cir.1997), *cert. denied,* 522 U.S. 1119, 118 S.Ct. 1059, 140 L.Ed.2d 121 (1998). Finally, where we are confronted with mixed questions of fact and law, we apply the clearly erroneous standard except that the District Court's choice and interpretation of legal precepts remain subject to plenary review. *Mellon Bank, N.A. v. Metro Communications, Inc.,* 945 F.2d 635, 641-42 (3d Cir.1991).

IV. Health Care Quality Improvement Act Immunity

In 1986 Congress enacted the Health Care Quality Improvement Act. As the name suggests, the purpose of the HCQIA was to improve the quality of medical care by restricting the ability of physicians who have been found to be incompetent from repeating malpractice by moving from state to state without discovery of such finding. 42 U.S.C. § 11101; H.R.Rep. No. 99-903 at 2, *reprinted in* 1986 U.S.C.C.A.N. 6384-6391. *See also Mathews,* 87 F.3d at 632 (recognizing the purpose of the HCQIA). The HCQIA established a national reporting system requiring that insurance companies report medical malpractice payments made; that boards of medical examiners report sanctions imposed against physicians; and that hospitals report adverse professional review information. 42 U.S.C. §§ 11131-33. To support that purpose and ensure that both hospitals and doctors engage in meaningful professional review, Congress provided immunity to those persons participating in professional review activities. See 42 U.S.C. § 11101(5), 11111(a); H.R. Rep. 99-903 at 2-3, *reprinted in* 1986 U.S.C.C.A.N. at 6385. Specifically, the

Act provides that persons participating in professional review activities or providing information to professional review bodies are immune from suit for money damages arising out of their participation in such activities. 42 U.S.C. § 11111(a)(1)-(2). At its heart, the HCQIA was intended to deter antitrust suits by disciplined physicians. *Mathews*, 87 F.3d at 633.

Only actions that meet the definition of professional review action are eligible for immunity under the HCQIA. H.R.Rep. No. 99-903 at 21, *reprinted in* 1986 U.S.C.C.A.N. at 6403. The HCQIA defines "professional review action" as:

> [A]n action or recommendation of a professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action.

42 U.S.C. § 11151(9). In order to qualify for HCQIA immunity, a professional review action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality healthcare,
>
> (2) after a reasonable effort to obtain the facts of the matter,

> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

Id. at § 11112(a). A professional review action will be presumed to have met the preceding standards necessary for immunity to attach unless the presumption is rebutted by a preponderance of the evidence. *Id.* The HCQIA places a high burden on physicians to demonstrate that a professional review action should not be afforded immunity. 42 U.S.C. § 11112(a). In fact, an action is presumptively immune if it was made "in the reasonable belief that the action was in furtherance of quality health care." 42 U.S.C. § 11112(a). This test will be satisfied "if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." H.R.Rep. No. 99-903 at 10, *reprinted in* 1986 U.S.C.C.A.N. at 6393; 42 U.S.C. § 11112(a).

As we previously recognized, this presumption of immunity creates an unusual standard for reviewing summary judgment orders, as the plaintiff bears the burden of proving that the professional review process was not reasonable and thus did not meet the standard for immunity. *Mathews,* 87 F.3d at 633. *See also Pamintuan v. Nanticoke Memorial Hosp.,* 192 F.3d 378, 388 (3d Cir.1999). But Gordon attempts to avoid application of this presumption of immunity by attacking the actions taken

against him on grounds that they were not "professional review actions" within the meaning of the HCQIA, 42 U.S.C. § 11151(9). It is Gordon's position that the professional conduct at issue did not affect adversely the health or welfare of patients as required by § 11151(9), and therefore there was no professional review action to confer immunity on the Hospital. He asserts that he only could be expelled from the medical staff as a result of a professional review action if it was based on either his competence or his professional conduct, which conduct affects or could affect adversely the health or welfare of a patient or patients. *See* 42 U.S.C. § 11151(9). Since his professional competence has never been in dispute, Gordon argues that he was expelled for his conduct in violating the Conditions – his telephone conversation with Mrs. Seecora and the June 4th letter. According to Gordon, in order to qualify its actions based on that conduct as a "professional review action" entitled to immunity under the HCQIA, the Hospital bore the burden to show that his conduct "could affect adversely the health or welfare of patients".[13]

The Conditions were imposed upon Gordon for the purpose of deterring Gordon's harassment and intimidation of elderly patients by calling them to disparage

[13] We note that the arguments of The Pennsylvania Medical Society ("PMS") as amicus for Gordon promote our adoption of a heightened standard for providing HCQIA protection to a professional review action premised on physician conduct rather than competence. PMS suggests that the nexus between the physician conduct and adverse effect on patient welfare be judged by a standard of "concrete harm" or a realistic projection of it. However, as discussed *infra*, such a construction is not supported by the statute, as it conflicts with the objective standard applicable for the presumption of immunity – when an action is undertaken "in the reasonable belief that the action was in the furtherance of quality health care." 42 U.S.C. § 11112(a).

Nancollas's skills. The record contains a plethora of evidence that Gordon's conduct in violating the Conditions could affect adversely the health or welfare of patients. Perhaps most compelling is the testimony of Mrs. Seecora's daughter regarding the effect on her eighty-two year old mother of Gordon's derogatory comments about Nancollas. Additionally, Everhart testified that Gordon's behavior was unprofessional and posed a threat to patient care. The Hearing Officer concluded that perhaps no conditions could be drafted sufficient to protect the Hospital and its patients from Gordon's poor judgment. The Appellate Review Panel upheld the recommended credentialing action because the Seecora phone call demonstrated that Gordon continued to harass, intimidate and upset elderly and vulnerable hospital patients.

Such unprofessional conduct on the part of a physician is within the purview of a "professional review action" under the HCQIA. The plain language of the statute indicates the breadth of "conduct" encompassed within the definition of "professional review action" by the inclusion of conduct that "could affect adversely the health or welfare of a patient." 42 U.S.C. § 11151(9). The statute contemplates not only potential harm through use of the term "could," but it also affords protection to actions taken against physician conduct that either impacts or potentially impacts patient "welfare" adversely, meaning patient "well being in any respect; prosperity." Black's Law Dictionary (West Group, 7th Ed.1999). Even if the statutory language was deemed to be ambiguous, the legislative history would support the same construction. *See* Health Care Quality Improvement Act of 1986, H.R. 5540, 99th Cong.2d Session (1986), 132 Cong. Rec. at 30768 (Oct. 14, 1986) ("competence and professional conduct should be

interpreted in a way that is sufficiently broad to protect legitimate actions based on matters that raise concerns for patients or patient care."). Other courts similarly have applied immunity in circumstances where a physician's unprofessional "conduct" was an issue in the challenged professional review actions. *See, e.g., Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 835 (3d Cir.1999) (affirming summary judgment in favor of Hospital afforded HCQIA immunity for peer review decisions involving a surgeon characterized as "a disruptive force in the hospital"); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1324 (11th Cir.1994) (granting immunity when physician's privileges revoked for inappropriate and unprofessional behavior stemming from his "being a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who regularly viewed it as his obligation to criticize staff members at [the Hospital] for perceived incompetence or inefficiency," some of which occurred in front of patients about to undergo surgery); *Morgan v. PeaceHealth, Inc.*, 101 Wash.App. 750, 14 P.3d 773 (2000) (upholding immunity when physician's privileges suspended for sexual harassment and inappropriate behavior with patients); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir.2003) (upholding immunity when physician's reappointment denied because of failure to timely disclose disciplinary actions in another state, personality problem and various incidents of disruptive behavior); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026 (4th Cir.1994) (affirming district court order granting summary judgment to hospital where physician's reappointment to staff denied on basis of hospital's conclusion that his professional activities did not meet standard of care, he was deficient in his record keeping, patient management, and work

relationships with health care professionals at the hospital).

Gordon simply cannot escape the ramifications of his conduct by relying on a tortured construction of the statute that ignores the fact that, at all levels of the process, his conduct was found to adversely impact patient health or welfare. There is no question on this record that Gordon's conduct towards Mrs. Seecora adversely affected her welfare given that Gordon's comments caused her to question her decision to allow Nancollas to operate on her cataract in March of 1997. Nor will this Court substitute its judgment for that of health care professionals and the governing body of the Hospital as to whether Gordon's conduct either did or could have an adverse impact on patient health or welfare. *See Brader,* 167 F.3d at 843 (citing *Bryan v. James E. Holmes Regional Medical Center,* 33 F.3d 1318, 1337 (11th Cir.1994)); *see also Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064 (8th Cir.2005). Accordingly, Gordon's arguments in this regard, though creative, must fail.

Gordon argues alternatively that his conduct with which the Hospital took issue falls within the ambit of the solicitation exception to professional review action. The HCQIA exempts from "professional review action" a number of actions not considered to be based on the competence or professional conduct of a physician. *Id.* One such exemption is the "solicitation exception," which excludes from HCQIA coverage actions "based on the competence or professional conduct of a physician if the action is primarily based on . . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.* at 11151(9)(B).

In denying the motions for summary judgment as to HCQIA immunity, the District Court initially determined that the applicability of HCQIA immunity turned on whether Gordon's conduct (viewed from his subjective perspective) in contacting Mrs. Seecora and in mailing the June 4, 1997 letter was intended to solicit or retain business. But upon reconsideration, the District Court determined that the relevant intent is that of the Hospital in undertaking the action, not whether the physician had the subjective intent to solicit business when engaging in the conduct at issue. If the action were "primarily based on" conduct relating to the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business, then the action would be excluded from HCQIA coverage as a "professional review action." Ultimately, the lack of evidence that the action was "primarily based on" Gordon's efforts to solicit or retain business proved dispositive and the Hospital was granted immunity from money damages under the HCQIA.

We conclude the District Court's construction upon reconsideration to be correct.[14] "It is elementary that the

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[14] Amicus for the Hospital, the Hospital & Healthsystem Association of Pennsylvania ("HAP"), aptly argue that the District Court initially erred in focusing on Gordon's subjective intent because "[w]hat the solicitation exception actually excludes is a review action based upon the mere fact that a physician has engaged in activities with the intent to solicit or retain business; it does not exclude actions taken on the basis of the review committees' reasonable conclusion that the physician's activities (whether or not intended to solicit business) are unprofessional." We agree with amicus's further assertion that if HCQIA immunity hinged on the disruptive physician's subjective intent, every disruptive physician would claim that the unprofessional conduct being reviewed was intended for a competitive purpose in order to invoke the solicitation exception to professional review action.

meaning of the statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain . . . the sole function of the courts is to enforce it according to its terms." *Abdul-Akbar v. McKelvie,* 239 F.3d 307, 312 (3d Cir.), *cert. denied,* 533 U.S. 953, 121 S.Ct. 2600, 150 L.Ed.2d 757 (2001). The plain language of the solicitation exception focuses on the basis of the "action" taken by the professional review body, not on the conduct of the physician precipitating the action – "*an action* is not considered to be based on the competence or professional conduct of a physician *if the action is primarily based* on . . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." 42 U.S.C. § 11151(9)(B) (emphasis added). Our precedent applying an objective standard to determine immunity from money damages under 42 U.S.C. § 11112(a) further supports this construction. *See Mathews,* 87 F.3d at 635 (holding that § 11112(a) of the HCQIA imposes an objective standard which is met when peer reviewers reasonably conclude that their actions will restrict incompetent behavior or protect patients and recognizing that an objective standard furthers Congressional intent that immunity issues may be resolved at summary judgment); *Brader,* 167 F.3d at 840 ("Like other circuits, we have adopted an objective standard of reasonableness in this context."). *See also* H.R. Rep. 99-903 at 10, *reprinted at* 1986 U.S.C.C.A.N. at 6392-93 (adopting objective standard that a professional review action must be undertaken in the reasonable belief that it is in furtherance of quality healthcare and rejecting a "good faith" standard as being capable of being misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional review action). Consequently, even when the solicitation exception is in

play, immunity will be judged by applying the objective standard regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare. *See* 42 U.S.C. § 11112(a).

The real issue in this regard is the sufficiency of the basis for the Hospital's actions, i.e., whether it was undertaken to protect patients. *See Brader,* 167 F.3d at 840. *See also Manion v. Evans,* Civ. No. 89-7436, 1991 WL 575715 at *8 (N.D.Ohio 1991), *appeal dismissed,* 986 F.2d 1036 (6th Cir.), *cert. denied,* 510 U.S. 818, 114 S.Ct. 71, 126 L.Ed.2d 40 (1993) (hospital granted HCQIA immunity at summary judgment where physician invoked solicitation exception to professional review action but evidence supported conclusion that actions were "motivated solely by [the Committee's] concern for the well being of patients," thereby placing the burden upon physician to produce evidence that the Committee was not engaged in a professional review action); *Rogers v. Columbia/HCA,* 971 F.Supp. 229 (W.D.La.1997), *aff'd,* 140 F.3d 1038 (5th Cir.1998) (primary reason for disciplinary action was professional competence despite competition between peer review committee and disciplined physician). This standard is an objective one that looks to the totality of the circumstances. *Mathews,* 87 F.3d at 635 (citing *Imperial,* 37 F.3d at 1030). Of course, as with any challenge to the applicability of immunity to a professional review action, the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action. 42 U.S.C. § 11112.

The record here establishes that the 1997 revocation of Gordon's Medical-Dental Staff privileges resulted from concern for patient welfare. Gordon's attempts to couch his telephone calls to Mrs. Seecora to fit within the parameters

of the solicitation exception are disingenuous based on the extensive record before this Court chronicling Gordon's continued inappropriate conduct undertaken to advance his personal agenda to the detriment of patient welfare. To hold otherwise on a record such as this would effectively chill effective peer review by permitting the subject of the peer review process to control the application of HCQIA immunity by couching his or her intentions to fit within the solicitation exception to "professional review action."

Based on the foregoing discussion, we will affirm the determination of the District Court to confer upon the Hospital HCQIA immunity from money damages.

V. Antitrust Claims Requiring Concerted Activity

Gordon set forth multiple antitrust claims requiring proof of concerted activity or conspiracy. These claims invoked both Section 1 of the Sherman Act (*see* Counts I (Conditions as restraint of trade), IV (reciprocal dealing), V (group boycott) and VI (exclusive dealing)) and Section 2 of the Sherman Act (*see* Counts VII and VIII (conspiracy to monopolize markets)). The District Court granted summary judgment on grounds that there was no proof of concerted activity or conspiracy between the Hospital and Geisinger and/or Postal in undertaking disciplinary action against Gordon to restrain his ability to provide patients with competitive information.[15] Gordon challenges the

[15] The District Court initially granted summary judgment for the Hospital as to Count I (Conditions as restraint of trade). But upon reconsideration, the Court determined that it had erred by including this as a claim that required the existence of concerted activity or a conspiracy in order to survive summary judgment. Because there was a

(Continued on following page)

District Court's grant of summary judgment in favor of the Hospital as to those claims. He also challenges the District Court's entry of judgment for the Hospital at the conclusion of the non-jury trial as to Count I (Conditions as restraint of trade). Because concerted action is required for all of the aforementioned claims, we first address its parameters. We then address Gordon's challenge to the claims disposed of at summary judgment followed by our analysis of Gordon's challenge to the District Court's post-trial rulings regarding Count I (Conditions as restraint of trade).

A. Concerted Activity

Section 1 of the Sherman Act provides:

> Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

15 U.S.C. § 1. To establish a violation of Section 1, a plaintiff must prove: (1) concerted action by the defendants; (2) that produced anti-competitive effects within the relevant product and geographic markets; (3) that the concerted actions were illegal; and (4) that it was injured as a proximate result of the concerted action. *Petruzzi's IGA Supermarkets, Inc. v. Darling-Delaware Co.*, 998 F.2d 1224, 1229 (3d Cir.), *cert denied sub nom. Moyer Packing Co. v. Petruzzi's IGA Supermarkets, Inc.*, 510 U.S. 994, 114 S.Ct. 554, 126 L.Ed.2d 455 (1993). *See also Big Apple BMW, Inc. v. BMW of North Am. Inc.*, 974 F.2d 1358, 1364

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genuine issue of material fact regarding the relevant geographic market, that claim was part of the non-jury trial.

(3d Cir.1992), *cert. denied,* 507 U.S. 912, 113 S.Ct. 1262, 122 L.Ed.2d 659 (1993). Without proof of all of these elements, a Section 1 claim cannot be maintained. *Id.*[16]

The essence of a Section 1 claim is the existence of an agreement. *Mathews,* 87 F.3d at 639 (citing *Alvord-Polk, Inc. v. F. Schumacher & Co.,* 37 F.3d 996, 999 (3d Cir.1994), *cert denied,* 514 U.S. 1063, 115 S.Ct. 1691, 131 L.Ed.2d 556 (1995)). Unilateral action simply does not support liability; there must be a "unity of purpose or a common design and understanding or a meeting of the minds in an unlawful arrangement." *Siegel,* 54 F.3d at 1131 (quoting *Copperweld Corp. v. Independence Tube Corp.,* 467 U.S. 752, 771, 104 S.Ct. 2731, 81 L.Ed.2d 628 (1984)). Concerted action is established where two or more distinct entities have agreed to take action against the plaintiff. *See Weiss v. York Hosp.,* 745 F.2d 786, 812 (3d Cir.1984). Accordingly, it requires proof of a causal relationship between pressure from one conspirator and an anticompetitive decision of another conspirator. *See Big Apple BMW,* 974 F.2d at 1364.

B. Claims Disposed of at Summary Judgment

Gordon challenges the grant of summary judgment in favor of the Hospital on those of Gordon's antitrust claims that require concerted action or conspiracy, concluding that there was no genuine issue of material fact regarding the concerted action. These include claims brought under

[16] Claims for conspiracy to monopolize under Section 2 of the Sherman Act also require evidence of a conspiracy. 15 U.S.C. § 2. Section 2 of the Sherman Act prohibits monopolization, attempts to monopolize and conspiracies to monopolize any part of interstate trade or commerce.

Section 1 of the Sherman Act (Count IV (reciprocal dealing), Count V (group boycott), Count VI (exclusive dealing)) and claims brought under Section 2 of the Sherman Act (Counts VII and VIII (conspiracy to monopolize markets)). Gordon argues that the District Court erred given that the existence of concerted action is a fact-intensive inquiry not appropriate for summary judgment.

Our review of a grant of summary judgment is plenary. *Mathews,* 87 F.3d at 639. Summary judgment must be granted where no genuine issue of material fact exists for resolution at trial and the moving party is entitled to judgment as a matter of law. *Id.* citing Fed.R.Civ.P. 56(c). The moving party bears the burden of showing the absence of any genuine issues of material fact. *See Celotex Corp. v. Catrett,* 477 U.S. 317, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). A non-movant's burden in defending against summary judgment in an antitrust case is no different than in any other case. *In re Flat Glass Antitrust Litigation,* 385 F.3d 350, 357-58 (3d Cir.2004); *Petruzzi's,* 998 F.2d at 1230 (citing *Big Apple BMW,* 974 F.2d at 1363).

When the question involves concerted action, the nonmovant may rely solely on circumstantial evidence and the reasonable inferences drawn therefrom to withstand summary judgment. *Id.* But this requires more than mere complaints of concerted action. There must be evidence that tends to exclude the possibility of independent action, meaning that the evidence reasonably tends to prove that the alleged conspirators had a conscious commitment to a common scheme designed to achieve an unlawful objective. *See Big Apple BMW,* 974 F.2d at 1364, citing *Monsanto Co. v. Spray-Rite Serv. Corp.,* 465 U.S. 752, 764, 104 S.Ct. 1464, 79 L.Ed.2d 775 (1984); *Alvord-Polk,* 37 F.3d at 1001. This is because mistaken inferences in this context may

serve to chill the very conduct that the antitrust laws are designed to protect. *Alvord-Polk,* 37 F.3d at 1001 (*citing Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 594, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986); *Monsanto,* 465 U.S. at 763-64, 104 S.Ct. 1464). If such a showing is made, the movant bears the burden of proving that drawing an inference of unlawful behavior is unreasonable. *Id.* Evidence of conduct that is as consistent with permissible competition as with illegal conspiracy, without more, will not support an inference of conspiracy. *Alvord-Polk,* 37 F.3d at 1001. *See also Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986).

Gordon takes exception to the District Court's conclusion that the Hospital's progressive discipline towards Gordon, which ultimately led to the 1996 suspension and 1997 revocation of his Medical-Dental Staff privileges, was unrelated to pressure from Geisinger. Gordon contends that there was ample evidence that Geisinger pressured the Hospital to muzzle his criticism of Nancollas, and that the Hospital did so without any independent permissible basis. He points to the Hospital's 1989 refusal to discipline him for the comments he made about Nancollas to a nursing home patient as compared to the actions undertaken in 1996-97 when the Hospital was concerned regarding Geisinger's renewal of its lease. According to Gordon, it follows that the Hospital strayed from its prior position of ignoring his conduct outside the Hospital and succumbed to pressure from Geisinger to muzzle Gordon by first

suspending and then revoking his Medical-Dental Staff privileges.[17]

We conclude, however, that the record evidence supports the District Court's conclusion. The whole of the evidence simply does not exclude the possibility that the Hospital acted independently in undertaking its professional review actions. *See Big Apple BMW,* 974 F.2d at 1365. No evidence of record exists to permit even an inference of a causal connection between Geisinger and the professional review actions resulting in the suspension and revocation of Gordon's privileges. *Id.* at 1364 ("A jury may not be permitted to speculate as to cause . . . ; the plaintiff must demonstrate . . . 'a unity of purpose or a common design and understanding, or a meeting of the minds.'"). Gordon relies on the Hospital's "shift" in its response to Gordon's conduct, asserting that discipline only was undertaken in 1995 and 1996 given pressure from Geisinger, on which the Hospital was economically dependent. *Big Apple BMW,* 974 F.2d at 1365 (evidence of concerted action spanning several years existed including meetings among dealers indicating their opposition to new franchisees); *Arnold Pontiac-GMC, Inc. v. General Motors Corp.,* 786 F.2d 564 (3d Cir.1986) (evidence of concerted action where after meeting with a competitor of plaintiff, dealer denied plaintiff's franchise application despite

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[17] In addition to being the Chairman of the Hospital Board of Trustees, Postal also was the Chairman of the Mifflin County Industrial Development Authority, which was involved in advancing the financing for the Hospital Medical Arts Building in which Geisinger leased space. In light of this, Gordon attempts to link Postal's involvement in effecting Gordon's agreement to the Conditions (which he alleges "gagged" him from conveying information regarding Nancellas) to his interest in renewing the Geisinger lease.

previous affirmative steps taken toward granting the franchise). But there is no evidence of Geisinger's involvement in the professional review action that resulted in the revocation of Gordon's Medical-Dental Staff privileges. A review of Gordon's tenure as a member of the Hospital's Medical-Dental Staff reveals a consistent pattern of disruptive and unprofessional conduct. The independence of the Hospital's actions in 1996 is not trumped simply because the Hospital's discipline of Gordon became increasingly severe over time. As we recognized in *Mathews*, "[s]imply making a peer review recommendation does not prove the existence of a conspiracy [among the hospital and its staff]; there must be something more such as a conscious commitment by medical staff to coerce the hospital into accepting its recommendation." *Mathews*, 87 F.3d at 639-640. Moreover, peer review actions, when properly conducted, generally enhance competition and improve the quality of medical care. *Id.* at 640 (citing *Weiss v. York Hosp.*, 745 F.2d 786, 821 n. 60 (3d Cir.1984)). Although theoretically the lease could support an inference that Geisinger's economic power may have had some influence on the Board's decision, Gordon has not produced any evidence of any communication between the Hospital and Geisinger regarding the revocation of Gordon's Medical-Dental privileges. Gordon also has not raised a genuine issue of material fact that Geisinger coerced the Hospital into revoking Gordon's Medical-Dental Staff privileges. There is as well no evidence to exclude the possibility that the Hospital acted independently in undertaking progressive peer review of Gordon. This precludes an inference of antitrust conspiracy. *Mathews*, 87 F.3d at 640-41.

Accordingly, we will affirm the grant of summary judgment to the Hospital as to Counts IV (reciprocal dealing), V (group boycott), VI (exclusive dealing), VII and VIII (conspiracy to monopolize markets).

C. Post-trial Judgment Regarding Count I

Judgment was entered in favor of the Hospital following a non-jury trial as to Count I (Conditions as restraint of trade) in which Gordon alleged that the Hospital and the Chairman of the Hospital Board, Postal, imposed the Conditions to prevent Gordon from competing to retain or obtain business by communicating truthful non-deceptive information to patients relevant to their surgical decisions. He asserts that the Conditions constituted an unreasonable restraint of trade in that they foreclosed him from competing in the physician services market for outpatient cataract surgery, inpatient eye surgery and emergency eye surgery. It also is asserted that the Hospital sought to prevent MCCSC from competing with it in the facility services market for outpatient cataract surgery.

Gordon specifically contends that the District Court erred in concluding that he failed to sustain his burden of proving a *prima facie* case under the traditional rule of reason test. First, Gordon challenges the District Court's application of the traditional rule of reason rather than the "quick look" rule of reason analysis. The latter applies in cases where *per se* condemnation is inappropriate but where no elaborate industry analysis is required to demonstrate the anticompetitive character of an inherently suspect restraint. *United States v. Brown Univ.*, 5 F.3d 658, 669 (3d Cir.1993). Rather, the competitive harm is presumed and the defendant must set forth some competitive

justification for the restraints. *Id.* Gordon contends that the information restraints were manifestly anticompetitive and not supported by any pro-competitive justification. Despite Gordon's protestations, the quick look approach may be applied only when an observer with even a rudimentary understanding of economics could conclude that the arrangement in question would have an anticompetitive effect on customers and markets. *California Dental Ass'n v. FTC*, 526 U.S. 756, 770, 119 S.Ct. 1604, 143 L.Ed.2d 935 (1999). Such is not the case here, where even if the Conditions were a restraint, they represent a non-price vertical restraint between one hospital and one physician, which we have held is reviewed under the traditional rule of reason. *See Orson Inc. v. Miramax Film Corp.*, 79 F.3d 1358, 1368 (3d Cir.1996) ("[v]ertical restraints of trade, which do not present an express and implied agreement to set resale prices, are evaluated under the rule of reason."). This is especially true given the District Court's determination, with which we agree, that Gordon and the Hospital were not competitors in the relevant market in November 1995 when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later.

Application of the traditional "rule of reason" requires that a factfinder look at the totality of the circumstances in order to determine whether a business combination constitutes an unreasonable restraint of trade. *Brown Univ.*, 5 F.3d at 668. Under this test, Gordon bears the initial burden of showing that the alleged contract produced an adverse, anticompetitive effect within the relevant geographic market. *Id.* This can be achieved by demonstrating that the restraint is facially anticompetitive or that its

enforcement reduced output, raised prices or reduced quality. *Id.* Alternatively, because proof that the concerted action actually caused anticompetitive effects is often impossible to sustain, proof of the defendant's market power will suffice. *Id.; F.T.C. v. Indiana Federation of Dentists,* 476 U.S. 447, 460-61, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986). Market power, the ability to raise prices above those that would otherwise prevail in a competitive market, is essentially a surrogate for detrimental effects. *Brown Univ.,* 5 F.3d at 668. We must be mindful that

> the legality of an agreement or regulation cannot be determined by so simple a test . . . as whether it restrains competition. Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain is of their very essence. The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. To determine that question, the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be obtained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

Board of Trade of the City of Chicago v. United States, 246 U.S. 231, 238-39, 38 S.Ct. 242, 62 L.Ed. 683 (1918). *See*

also Eichorn v. AT & T Corp., 248 F.3d 131, 144-45 (3d Cir.), *cert. denied*, 534 U.S. 1014, 122 S.Ct. 506, 151 L.Ed.2d 415 (2001) (indicating totality of circumstances considered under rule of reason includes facts peculiar to particular business to determine the nature and purpose of the allegedly illegal restraint).

Although the District Court determined that Gordon met the concerted action requirement for purposes of this Sherman § 1 claim through the existence of the Conditions of his reappointment, the District Court also determined that he failed to meet his burden of proving that enforcement of the Conditions by excluding him from the Medical-Dental Staff had anticompetitive effects. In applying the traditional rule of reason, we first must determine whether the Conditions had substantial anticompetitive effects. Gordon argues that the Conditions reduced output given that the output of a surgeon is not only the surgery itself but necessarily includes advice, scheduling, and hand-holding. *See National Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Okla.*, 468 U.S. 85, 99, 104 S.Ct. 2948, 82 L.Ed.2d 70 (1984) (restrictions on output are unreasonable restraints of trade). Gordon claims that the Conditions impaired historically effective competition between surgeons competing to provide surgery services by prohibiting him from conveying comparative information regarding procedures that were essential for patients to make informed decisions. In advancing his argument, Gordon asserts that Condition 3 prevents him from communicating with Nancollas's patients or any other physician's patients for the purpose of conveying comparative information and that it prevents him from making "any comment" at any time about "any other ophthalmologist" with any person in the Hospital's service area. But Condition

3 only serves to chill Gordon's comments regarding other ophthalmologists as part of his discharge instructions or at any other time when dealing with patients who have been or will be treated by the Hospital, excepting comments made "in response to a specific question or for the purpose of a referral." In light of Gordon's history, precluding him from making gratuitous statements at any time and in whatever fashion he deemed appropriate regardless of its impact or potential impact on patient health or welfare does not, standing alone, elevate Condition 3 to having anticompetitive effects. Likewise, as the District Court determined, Condition 2 only prohibited Gordon from commenting upon a particular surgical method as it relates to a particular physician, and not, as Gordon contends, from differentiating himself and his methods in surgical meetings.

Next, we must determine whether the Hospital possessed market power in the relevant markets in order to determine if we may presume anticompetitive effects from the Conditions under the rule of reason test. Determination of market power is a determination of fact; therefore we review the District Court's conclusions to determine if they are clearly erroneous. *Igbonwa,* 120 F.3d at 440. Gordon bore the burden of proving the relevant product and geographic markets affected by the Hospital's imposition of the Conditions. *Eichorn v. At & T Corp.,* 248 F.3d 131, 147 n. 4 (3d Cir.2001). Once the markets are defined, we must determine whether the Hospital's market share is sufficient to infer the existence of market power. *Fineman v. Armstrong World Industries, Inc.,* 980 F.2d 171, 201-02 (3d Cir.1992). The relevant product markets (each containing a facility and physician services component) are: (1) general outpatient cataract surgery, (2)

general inpatient cataract surgery; and (3) general emergency eye surgery. Gordon disputes the District Court's findings regarding the geographic market definition and determination of market power.

The relevant geographic market, from which the court calculates the market share in the relevant product markets, is that area in which a potential buyer may rationally look for the goods or services he seeks. *Pennsylvania Dental Ass'n v. Medical Service Ass'n of Pa.*, 745 F.2d 248 (3d Cir.1984). The geographic scope of a relevant product market is a question of fact to be determined in the context of each case in acknowledgment of the commercial realities of the industry being considered. *Borough of Lansdale v. Philadelphia Elec. Co.*, 692 F.2d 307, 311 (3d Cir.1982).

Gordon ascribes error to the District Court's determination that the relevant geographic market for general outpatient cataract surgery consisted of all hospitals and surgical centers performing outpatient cataract surgery within a 30 mile radius of Lewistown, rather than only Mifflin and Juniata counties as he had proposed.[18] He argues that defining a geographic market demands a review from the consumer's perspective and that the District Court's thirty mile radius of Lewistown ignores the geography of the region – that Mifflin and Juniata Counties sit within a valley that was isolated by mountain ranges making the actual distances that patients must travel much greater than that perceived when relying on

[18] The geographic market as defined by the District Court included Mifflin and Juniata Counties in addition to portions of Snyder, Union, Clinton, Centre, Huntington, Franklin, Cumberland and Perry Counties.

an "as the crow flies" radius. Gordon essentially seeks to substitute the Hospital's primary service area for the relevant geographic market. Absent more, however, a primary service area does not equate to the relevant geographic market for outpatient cataract surgery services. *See Miller v. Indiana Hosp.*, 814 F.Supp. 1254, 1263 (W.D.Pa.1992), *aff'd*, 975 F.2d 1550 (3d Cir.1992), *cert. denied*, 507 U.S. 952, 113 S.Ct. 1366, 122 L.Ed.2d 744 (1993).

The District Court's findings regarding the scope of the geographic market were not clearly erroneous. The District Court determined from its review of Gordon's expert's report and testimony that the greater the importance of the medical procedure to patients, the greater the willingness of the patients to travel to receive that service. Further, the evidence revealed that two-thirds of the patients that live within eight miles of the Hospital received cataract surgery elsewhere. Conversely, approximately 21% of the Hospital's patients for outpatient cataract surgery live closer to other facilities yet chose Lewistown Hospital. Gordon's proposed two-county market excluded competitors for cataract surgery facilities services located in other counties to whom Lewistown area optometrists referred patients, including, among others, the J.D. Blair Hospital in Huntington, Centre Community Hospital in State College, Pinnacle Health System and Pennsylvania Eye Surgery Center in Harrisburg. Accordingly, the record supports the District Court's rejection of a two-county geographic market.

Gordon further challenges the District Court's determination that the Hospital lacked market power in the outpatient cataract surgery market even when using the District Court's thirty mile radius geographic market. He

asserts that the District Court erroneously calculated percentages of market power based on two demonstrative exhibits prepared by the Hospital. The first chart ("Gordon/Nancollas Procedures Chart") reflected all patients in the twenty-eight zip codes that were within the thirty mile radius of Lewistown from which the Hospital drew patients. It summarized the number of procedures performed by Gordon and Nancollas in 1996. Although the chart included some non-cataract procedures performed by those physicians, cataract procedures accounted for 95% of the total and reflected a Hospital market share of 46%. The second chart ("Ophthalmic Surgery Cases Chart") contained numbers for all ophthalmic surgeries performed on patients in the same twenty-eight zip codes but without identifying what percentage of those were cataract procedures. Using this chart, the District Court determined that the Hospital's market share was only 39%. Gordon contests this finding because the Ophthalmic Surgery Cases Chart reflects hundreds of specialized procedures that are not performed at the Hospital and necessarily are performed outside of the Hospital's service area. Instead, he advocates use of the Gordon/Nancollas Procedures Chart, which he claims more accurately described the cataract market. In either case, however, the market share is insufficient to prove market power. *Fineman,* 980 F.2d at 201 (50% share is insufficient as a matter of law to establish market power). In addition, the District Court analyzed a number of other scenarios, all falling well-below the legal threshold for market power. Perhaps most telling of the Hospital's lack of market power is the evidence that outpatient surgical volume at the Hospital declined significantly after Gordon left and that MCCSC became the dominant provider of outpatient cataract surgery within less than 2 years of the Hospital's decision

to revoke Gordon's Medical-Dental Staff privileges. *See Assam Drug Co. v. Miller Brewing Co.*, 798 F.2d 311, 318 (8th Cir.1986) (no market power because market share was declining). Despite Gordon's challenges, the District Court's finding that the Hospital lacked market power in the outpatient cataract surgery market was well supported by the evidence and therefore was not clearly erroneous.[19]

Based on the foregoing, we will affirm the judgment of the District Court regarding Count I (Conditions as restraint of trade).

VI. Illegal Tying

In Count II, Gordon asserted that the Hospital illegally tied its outpatient cataract facility services to the purchase of emergency ophthalmologic services from a Geisinger physician, Nancollas, in violation of Section 1 of the Sherman Act. Tying is selling one good (the tying product) on the condition that the buyer also purchase another, separate good (the tied product). *See Town Sound & Custom Tops, Inc. v. Chrysler Motors Corp.*, 959 F.2d

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[19] Although Gordon also challenges the District Court's finding that the Hospital lacked market power in the inpatient eye surgery market, he failed to meet his burden of proof that the Hospital possessed market power in that market, particularly since Gordon's expert testified that the market for inpatient eye surgery services is *de minimis*. We affirm the District Court's finding in this regard. Gordon also argued that he met the prima facie requirements even when utilizing the traditional rule of reason and that the Hospital failed to sustain its burden of proving that there was a pro-competitive benefit from the Conditions. However, we need not reach this issue given our conclusion that the District Court's findings in this regard were not clearly erroneous.

468, 475 (3d Cir.), *cert. denied,* 506 U.S. 868, 113 S.Ct. 196, 121 L.Ed.2d 139 (1992). The essential characteristic of a tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde,* 466 U.S. 2, 11, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984). Under the *per se* analysis, a plaintiff must prove that (1) the defendant sells two distinct products, (2) the seller possesses market share in the tying product market, and (3) a substantial amount of interstate commerce is affected. *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.,* 140 F.3d 494, 512-13 (3d Cir.1998). Applying the *per se* analysis, the District Court determined that Gordon failed to prove an essential element of his claim – that the tie impacted a substantial amount of interstate commerce. Because Gordon failed to present any evidence regarding either the patient volume effect or the dollar volume business that has been affected by the tied market of emergency eye surgery physician services, we conclude that the District Court's determination that the Hospital's alleged tie did not affect a substantial amount of interstate commerce was not clearly erroneous.[20]

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[20] Nor does Gordon's tying claim survive under a rule of reason analysis where he must prove that the revocation of his Medical-Dental Staff privileges unreasonably restrained competition in the market for emergency ophthalmologic physician services. Gordon cannot show that the Hospital's alleged tie of the emergency ophthalmologic surgery facilities to Nancollas's professional services unreasonably restrained competition, especially given that his own expert testified that the market for facility services was so small that he could not perform a geographic market analysis.

VII. Attempted Monopolization

To prove attempted monopolization (Count III), Gordon must prove that the Hospital (1) had specific intent to monopolize the relevant market, (2) engaged in anticompetitive or exclusionary conduct, and (3) possessed sufficient market power to come dangerously close to success. *Barr Laboratories, Inc. v. Abbott Laboratories,* 978 F.2d 98, 111 (3d Cir.1992). The District Court determined that Gordon's claim failed given that he could not show the Hospital's specific intent to monopolize the outpatient cataract surgery market or that the Hospital engaged in predatory conduct with a specific intent to monopolize. He challenges only the District Court's findings regarding the Hospital's attempt to impede MCCSC's competition in an attempt to maintain monopoly power in the outpatient ophthalmologic facility services market in violation of Section 2 of the Sherman Act.

Gordon contends that he offered direct evidence of both the Hospital's admissions of anti-competitive intent and of predatory acts violative of Section 2 of the Sherman Act. Specifically, he argues that the Hospital never suggested or proved any legitimate reason for its threats to an orthopedic surgeon who considered operating out of MCCSC; for the pressure exerted on an anesthesiologist not to work with Gordon at MCCSC; for its joint venture with Everhart's facility to counter Gordon's operations at MCCSC; or its market allocation agreement with Everhart. But it was Gordon's burden to show more than the Hospital's intention to prevail over MCCSC or to protect its market position relative to MCCSC. *Pennsylvania Dental,* 745 F.2d at 260-61; *Morris Communications Corp. v. PGA Tour, Inc.,* 235 F.Supp.2d 1269, 1286 (M.D.Fla.2002). Despite Gordon's arguments, predatory

intent cannot be inferred from anticompetitive practices. The District Court properly rejected his evidence of "predatory" or "exclusionary" practices because the conduct complained of was not conduct without a legitimate business purpose. Unfairness alone is not enough to classify even disreputable business conduct as predatory. *Id.* at 260-61. Perhaps most significant is the District Court's determination that rather than acting with a specific intent to monopolize, the Hospital was acting with a specific intent to discipline "a persistently obstreperous physician who stubbornly refused to comply with the standards of courtesy and professionalism expected of a medical doctor."[21] The record supports the District Court's

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[21] Gordon complains that the District Court determinations hinged on "inadmissible hearsay evidence" of his disruptive and obstreperous behavior from the records of the Hospital hearings. Gordon had filed a motion *in limine* to define the scope of the issues at trial and to limit the case to consideration of Conditions 2 and 3 and their competitive effect. The District Court entered an order that

> Defendant may produce evidence regarding any disciplinary actions taken, the findings of the disciplinary bodies, and most important, Defendant's subsequent consideration of any previous disciplinary actions taken against Dr. Gordon. However, neither the Defendant nor Plaintiffs will be permitted to relitigate the alleged misconduct.

Gordon contends here that the District Court's reliance on the documents offered by the Hospital from the disciplinary proceedings (offered for the limited purpose of showing that the prior disciplinary actions occurred, its consideration of them, and notice to Gordon of prior discipline), was improper. He asserts that the District Court based its finding of his disruptive behavior solely upon those disciplinary documents, which contained unrebutted and inadmissible hearsay. He further contends that because the order precluded relitigation of those issues, he did not rebut any of the evidence on which the District Court ultimately relied to find that he had a history of disruptive behavior.

(Continued on following page)

conclusion. Having found no clear error, we will affirm the District Court.

VII. CONCLUSION

Based on the reasoning set forth in this opinion, we will affirm the judgment of the District Court as to all claims raised in this appeal.

The admissibility of evidence is within the discretion of the trial judge, and admissibility rulings will not be disturbed on appeal absent an abuse of discretion. *See Affiliated Manufacturers, Inc. v. Aluminum Co. of Am.*, 56 F.3d 521, 525-26 (3d Cir.1995) (a district court's ruling as to admissibility of evidence is reviewed under an abuse of discretion standard, where the question involves the application of the Federal Rules of Evidence). When applying the traditional rule of reason to determine if the Conditions were reasonable, a court must review the totality of the circumstances. *Brown Univ.*, 5 F.3d at 668. Consequently, we find no abuse of discretion by the District Court for its consideration of documents from the disciplinary proceedings.

2003 WL 21739181 (M.D.Pa.))

United States District Court,
M.D. Pennsylvania.

Alan D. GORDON, M.D ; Alan D. Gordon, M.D., P.C.; Mifflin County Community Surgical Center, Inc., Plaintiffs

v.

LEWISTOWN HOSPITAL, Defendant

No. CIV.1:CV-99-1100.

July 11, 2003.

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ORDER

Between April 3 and April 23, 2002, the court conducted a non-jury trial in the captioned matter. The

following constitute the court's findings of fact and conclusions of law pursuant to Federal Rule of Civil Procedure 52(a).

I. *Findings of Fact*

A. *The Parties*

Plaintiffs in this action are Dr. Alan Gordon, M.D., Alan Gordon, M.D., P.C., and Mifflin County Community Surgical Center, Inc ("MCCSC"). Dr. Gordon is an ophthalmologist practicing in Lewistown, Pennsylvania. Alan Gordon, M.D., P.C. is a Pennsylvania professional corporation organized in 1981. MCCSC is a Pennsylvania corporation organized in 1998 and operating in Lewistown. Dr. Gordon is the sole stockholder in both MCCSC and Alan Gordon, M.D., P.C.

Defendant, Lewistown Hospital ("the Hospital"), is a general medical and surgical hospital. The Hospital provides primary and secondary levels of acute inpatient care. It also furnishes outpatient surgical facility services. The Hospital is the only hospital located in the area of Mifflin and Juniata Counties, Pennsylvania. The Hospital engages in activities which affect interstate commerce.

The Hospital, like most hospitals in the United States, has an organizational structure with three primary components. First, the Hospital has a Board of Trustees ("the Board") which has final decision-making authority on issues affecting the Hospital. Second, the Hospital's administration staff, led by the Hospital's Chief Executive Officer ("CEO"), oversees day-to-day operations. The Hospital does not employ any physicians. Instead, it grants physicians staff privileges to practice at the Hospital. These physicians compose the Hospital's third primary

component, the Medical-Dental Staff. A physician must be a member of the Medical-Dental Staff to practice at the Hospital.

B. *The Credentialing Policy and the Peer Review Process*

As part of its relationship with the Hospital, the Medical-Dental Staff engages in a process known as "peer review." During this process, select members of the Medical-Dental Staff, known as "the Credentials Committee," make recommendations to the Board on whether a particular physician meets the minimum professional requirements to practice at the Hospital. These decisions involve determining whether a physician should be admitted to the Medical-Dental Staff and, once admitted, whether a physician's privileges should be renewed. The Credentials Committee's decisions are guided by the Hospital's Credentialing Policy, which sets forth the minimum professional requirements for physicians practicing at the Hospital. The Medical-Dental Staff initially adopted the Hospital's Credentialing Policy in 1991. The Board approved the Credentialing Policy that same year. The most recent revisions to the Credentialing Policy occurred in February, 1997.

The Credentialing Policy states that "[a]ppointment to the medical staff is a privilege which shall only be extended to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy and in such policies as are adopted from time to time by the Board." (Def.Ex. 227(A)(1) at Article II, Part A, § 1.) Among other requirements, the Credentialing Policy states that only those physicians who can document "adherence to the ethics of

their profession" and an "ability to work harmoniously with others" are qualified for staff privileges at the Hospital. (*Id.* at §§ 2(d)(2) and (4).) To be eligible for reappointment to the Medical-Dental Staff, a physician must agree "to abide by all bylaws and policies of the hospital, [the Credentialing] policy and rules and regulations of the medical staff as shall be enforced from time to time during the time the individual is appointed to the medical staff. . . . " (*Id.* at Article II, Part C, § 2(b).)

The instant antitrust action arises out of the Hospital's decision to conditionally reappoint Dr. Gordon to the Medical-Dental Staff and its ultimate decision to revoke his privileges for violating those conditions. Plaintiffs claim that these actions constitute violations of Sections 1 and 2 of the Sherman Act. *See* 15 U.S.C. §§ 1 and 2.

C. *Dr. Gordon and Dr. Nancollas: A Comparison*

Dr. Gordon was initially appointed to the Hospital's Medical-Dental Staff in 1980. In 1982, Dr. Gordon became a certified member of the American Board of Ophthalmology. In 1989, he became a certified member of the American Board of Eye Surgeons. Dr. Gordon is widely respected as a surgeon. His medical competence is not at issue in this case.

In July of 1989, Dr. Paul Nancollas, M.D., joined the Medical-Dental Staff as an ophthalmologist. At all times since he joined the Hospital, Dr. Nancollas has been a member of the Geisinger Group-Lewistown, a group of physicians in Lewistown associated with the Geisinger Corporation. In 1991, Dr. Nancollas became certified by the American Board of Ophthalmologists. Unlike Dr. Gordon, however, Dr. Nancollas is not certified by the

American Board of Eye Surgeons. Through 1997, both doctors performed cataract removal surgery, although the two employ different procedures.[1] At the time he joined the Hospital, Dr. Nancollas performed what is called a "planned extracapsular cataract extraction" ("ECCE" or "extracapsular extract").

During ECCE, the physician makes an eight to twelve millimeter ("mm") incision in the patient's eye, removes the cataract (either in whole or in several fragments), and then inserts an artificial intraocular lens through the incision. Given the length of the incision required, the physician will normally make his incision in the sclera, the white vascular portion of the eye. This relatively large incision also necessitates that the physician use stitches to secure the wound structure while the eye heals.

For almost the entire length of his professional career, Dr. Gordon has primarily used a different cataract removal procedure, "phacoemulisification" ("phaco procedure" or "phaco"). During a phaco procedure, the physician can make a smaller incision, typically three to five mm. Dr. Gordon usually makes a 2.8 mm multi-plane incision in the cornea which requires no stitches to heal. After making the incision, a physician performing phaco inserts a microsurgical instrument – called a phacoemulsifier – through the incision. The phacoemulsifier uses ultrasonic energy to break the cataract into many, very

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[1] "A cataract is a clouding of the normally clear lens of your eye. The Latin word *cataracta* means 'waterfall' – imagine trying to peer through a sheet of falling water or through a frosty or fogged-up window. Clouded vision can make it more difficult to read, drive a car or see the expression on your friend's face." Http://www.mayoclinic.com/invoke.cfm?id=DS00050 (last visited June 17, 2003).

small fragments. The physician then suctions out the fragments through the incision. Because of the smaller incision, a physician using phaco may make his incision in the cornea as opposed to the sclera. Unlike the sclera, the cornea is not vascularized. Therefore, making the incision in the cornea exposes a patient to less risk of complications. Additionally, the recovery time for phaco procedures is generally shorter than ECCE procedures. For these reasons, by the mid-1990s, phaco became the preferred procedure of ophthalmologists in the United States.[2] Both procedures, however, are still practiced, and neither falls below the standard of care for outpatient cataract surgery.

The incision is not the only difference between Dr. Gordon's and Dr. Nancollas' surgical methods. Once he removes the cataract, Dr. Nancollas implants a seven mm non-foldable, rigid intraocular lens. Dr. Gordon, on the other hand, uses a foldable lens that he inserts through his smaller incision. Use of both lenses, however, falls within the applicable standard of care. Moreover, from the patient's perspective, the use of a foldable or non-foldable lens does not affect their ability to see.

The two physicians also employ different methods of anesthesia. Dr. Gordon generally uses only local topical anesthesia. That is, before surgery begins, Dr. Gordon bathes the patient's eye with a pledgit, a small piece of cotton soaked with local anesthesia and a dilating agent. The local anesthesia numbs the area around the eye. The patient is conscious throughout the procedure, and no injections are required. If the patient feels some

[2] Dr. Nancollas has since switched to phaco, although he still uses an approximately seven mm incision which requires stitches.

discomfort during the procedure, Dr. Gordon uses eye drops containing anesthesia to relieve the pain.

On the other hand, Dr. Nancollas uses a peribulbar block to anesthetize his patients for surgery. A peribulbar block requires that the physician inject a needle containing anesthesia into the portion of the muscle cone[3] directly below the eyeball.[4] In both forms of periocular anesthesia – peribulbar and retrobulbar blocks -- the doctor makes an injection without being able to see the end of the needle. This is important because, without being able to see the end of the needle, there is a greater risk that the physician will inadvertently puncture the ocular nerve, causing severe damage to the eye and other components of the central nervous system.

Because a peribulbar block injection is both painful and shocking to the patient, Dr. Nancollas gives his patients a sleep dose of general anesthesia, via an intravenous line, before administering the block. As a result, risks uniquely associated with Dr. Nancollas' anesthetic method include perforation of the eyeball, respiratory arrest, hemorrhage, eechymoses (bruising), and ptosis (droopy eyelid). Although a peribulbar block exposes a patient to more complications than does topical anesthesia, both methods are within the standard of care. In fact, a majority of cataract surgeons who now employ the phaco procedure still use either a retrobulbar or peribulbar block to anesthesize their patients. With the rare exceptions of a

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[3] The muscle cone is the area of muscle which encases the eyeball and the ocular nerve.

[4] When he first began at the Hospital, Dr. Nancollas employed a retrobulbar block in which he would insert the needle into the area of the muscle cone behind the eye.

retrobulbar hemorrhage – which was self-limiting and did not damage the patient's eye – and a case of ptosis – which did not interfere with the patient's vision and resolved once post-operative swelling subsided – Dr. Nancollas' patients have not experienced any complications from his choice of anesthesia.

D. *The Relevant History of Dr. Gordon's Tenure*

1. The 28 Day Suspension

Following a series of incidents involving Dr. Gordon and other physicians and nurses in late 1991 and 1992, the Credentials Committee recommended that the Board suspend Dr. Gordon's privileges for a period of twenty-eight days.[5] The Board agreed, and on August 3, 1992, then-Hospital President William DeWire wrote Dr. Gordon, informing him of the suspension. The Credentials Committee purposely chose a twenty-eight day suspension period to avoid reporting the matter to the National Practitioner Databank.[6] The Committee wanted to send Dr. Gordon a message regarding his behavior and ability to work with others, without significantly inhibiting his ability to practice medicine.

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[5] The events giving rise to this suspension are not relevant to the outcome of this case. *See Gordon v. Lewistown Hosp.*, CV:1-99-1100, order (M.D.Pa. Nov. 8, 2001) (holding that the Hospital may only present evidence of Dr. Gordon's conduct with respect to incidents which occurred after 1990 and have a bearing on its decision to impose Conditions 2 and 3 of the Conditions of Reappointment). Accordingly, the court will not go into any detail about these matters, except to note that Dr. Gordon had notice that he was being disciplined for these actions.

[6] The Hospital must report any suspension of over thirty days.

2. The 45 Day Suspension

In 1994, the Hospital began to receive complaints from patients and their families regarding harassing, inappropriate, and intimidating phone calls from Dr. Gordon. During these conversations, Dr. Gordon would attack and belittle the patients for choosing Dr. Nancollas as their ophthalmologist. Specifically, John Whitcomb, Hospital CEO and President from 1993 through May of 1997, received a letter from a former Dr. Gordon patient, Helen Miller. This seventy-two year old woman indicated to Whitcomb that Dr. Gordon complained to her about her decision to switch to Dr. Nancollas.

Additionally, Marilyn Shupp complained to Dr. Dan Creighton, former Chairman of the Credentials Committee, that Dr. Gordon had called her mother, Mary Lontz – another former patient of Dr. Gordon – the night before Lontz was scheduled to have cataract surgery with Dr. Nancollas. During that conversation, Dr. Gordon complained about Lontz's decision to use Dr. Nancollas.

Whitcomb also received a complaint from Ardella Paige that Dr. Gordon contacted her to inquire as to why she switched to Dr. Nancollas. On February 10, 1995, Whitcomb received yet another letter from a patient, Mildred Goss, complaining of Dr. Gordon's conduct. In that letter, Goss, a former patient of Dr. Gordon, explained that she received a phone call from Dr. Gordon inquiring as to why she decided to use Dr. Nancollas to treat an emergency eye problem. According to Goss, she told Dr. Gordon that an optometrist from Lewistown had referred her to Dr. Nancollas because Dr. Gordon was not available. Dr. Gordon responded by calling her "a liar" and then "ridiculed Dr. Nancollas and said he was still a student

and wasn't able to operate for cataracts." (Def.Ex. 226(a)(17).)

As a result of these troubling complaints, Hospital counsel wrote two letters to Dr. Gordon's counsel indicating that if the Hospital were to receive additional complaints from patients, the matter would be referred to the Medical-Dental Staff for investigation. Despite these warnings, Dr. Gordon's behavior did not abate. The Administration received two additional complaints from patients indicating that Dr. Gordon had placed unwanted and unsolicited calls to them complaining about their decision to use Dr. Nancollas.

Additionally, Whitcomb received a complaint regarding Dr. Gordon's behavior in the Same Day Surgery Unit on August 24, 1994. On that day, a nurse complained that Dr. Gordon failed to dictate a medical history and physical for one of his patients awaiting surgery. Despite being instructed twice that he would have to complete the dictation before the patient would be allowed into surgery, Dr. Gordon did not do so. When Dr. Gordon was reminded a third time, he simply wrote "heart and lungs clear" on the patient's record. The nurse refused to accept the record and would not allow Dr. Gordon to take the patient into the operating room. In response, Dr. Gordon stated in a loud voice that the nurse who refused to release his patient to surgery "didn't give a damn about the patients. . . . " (Def.Ex. 226(I) at ¶ II.B.) Dr. Gordon also screamed at the nurses on staff, "you are all assholes." (*Id.*) These statements were made in front of several patients.

Whitcomb referred these complaints to the Credentials Committee for investigation. On November 29, 1995,

the Credentials Committee issued its finding that, among other things,[7] Dr. Gordon had engaged in a series of inappropriate and harassing phone calls to patients and had acted inappropriately in the Same Day Surgery Unit on August 24, 1994. As a result, the Credentials Committee recommended that Dr. Gordon be suspended for forty-five days. By letter dated December 5, 1995, Whitcomb informed Dr. Gordon of the Credentials Committee's decision and his right to appeal that matter to a neutral arbitrator.

Dr. Gordon appealed that decision to the arbitrator. On July 1, 1996, the arbitrator issued her decision upholding the suspension. With regard to the incident in the Same Day Surgery Unit, the arbitrator found that Dr. Gordon inappropriately "chose to publicly confront the nurse. Not only was this disruptive, but it was ineffective in obtaining the result he sought. It was reasonable for the Credentials Committee to base Dr. Gordon's suspension, in part, on this behavior." (*Id.*) Additionally, the arbitrator criticized Dr. Gordon for his phone calls to former patients harassing them about choosing Dr. Nancollas as their ophthalmologist. With respect to these calls, the arbitrator stated:

> Dr. Gordon did not deny these calls occurred, although he could not recall the exact circumstances of several calls. He testified that he made the calls so that patients would look into alternatives, at the same time acknowledging that the calls would have the effect of increasing a

[7] The Credentials Committee also found that Dr. Gordon engaged in two other instances of misconduct, neither of which is relevant to this case. *See supra* at fn. 5.

> patient's anxiety and that patients could do little, if anything, to explore their alternatives on the eve of surgery. These phone calls show extremely poor judgment, and are, in my view, cruel to the patients about whom Dr. Gordon professes to care. Once again, whether Dr. Gordon's concerns about the adequacy of other physicians and other procedures are real is not the issue. *The issue is that the manner in which Dr. Gordon has chosen to express his concerns is unacceptable and disruptive to the Hospital.* The recommendation of the Credentials Committee to suspend Dr. Gordon's privileges for 45 days, based in part on these telephone calls, was reasonable and supported by the evidence.

(*Id.* at ¶ II.C (emphasis added).) The Hospital reported the suspension to the National Practitioner Databank.

3. The Intervening Summary Suspension

While Dr. Gordon was exhausting his appellate rights regarding the forty-five day suspension, Whitcomb received several more complaints from patients, physicians, and nurses regarding Dr. Gordon's conduct.[8] As a result, the Hospital summarily suspended Dr. Gordon's privileges on April 19, 1996, pending resolution of the appeal regarding the forty-five day suspension. Dr. Gordon also appealed the summary suspension to the arbitrator. By a letter dated May 20, 1996, the arbitrator upheld the summary suspension.

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[8] *See supra* at fn. 5.

4. The 1996 Conditions of Reappointment

During this period, the Hospital had before it Dr. Gordon's application for staff reappointment for the period from February, 1995 to January 1, 1997. As the events described above unfolded, the Credentials Committee considered denying the application. On August 2, 1996, Dr. Charles Everhart, Chairman of the Credentials Committee, wrote Dr. Gordon explaining the Hospital's position:

> The Credentials Committee has a very long history of dealing with problems created by your behavior and of imposing conditions and discipline in an effort to make you understand that your behavior cannot continue. A vastly disproportionate share of the Credentials Committee's time and of the Hospital's resources have been devoted to problems created by you. This is notice to you that those extensive efforts on your behalf are over. You will not be recommended for reappointment unless the Credentials Committee receives from you, absolute, credible assurances that you understand that your behavior has been inappropriate and that, in the future, you will consistently conduct yourself strictly in accordance with [the] standards outlined in this letter and with all hospital and medical staff bylaws and policies.

(Def.Ex. 227(A)(6) at ¶ 10.)

On August 14, 1996, Dr. Gordon responded to Dr. Everhart's letter stating, among other things:

> *I will use the administrative channels to register complaints* or concerns about poorly functioning equipment, or *about others practicing at the hospital* or assisting me.

* * *

> I find that my phone calls to patients were counterproductive and I stopped making these calls in late 1995. Although I feel that patients ought be informed of their situation, I have not called patients for sometime *nor is it my intention to call or otherwise attempt to communicate with the patients of any other ophthalmologist for the purpose of commenting on that physician's training, skill, or competency* or the procedure performed by such physician.

(Def.Ex. 227(A)(7) (emphasis added).)

Despite Dr. Gordon's conciliatory rhetoric, within a few weeks of returning to the Hospital after the forty-five day suspension, Dr. Gordon was involved in yet another incident. On September 5, 1996, Dr. Gordon and another physician engaged in a shouting match on the Hospital's third floor. Apparently, Dr. Gordon was infuriated because the other physician had referred a patient to Dr. Nancollas. Although Dr. Everhart – speaking on behalf of the Credentials Committee – expressed his displeasure regarding Dr. Gordon's involvement in the incident, no disciplinary action was taken against Dr. Gordon as a result of this event.

In a letter dated September 30, 1996, Dr. Everhart, writing on behalf of the Credentials Committee, indicated that the Hospital would recommend that Dr. Gordon be reappointed to the Medical-Dental Staff contingent upon his acceptance of seventeen "Conditions for Reappointment." On October 10, 1996, after consulting with counsel, Dr. Gordon agreed to the Conditions of Reappointment. On November 11, 1996, Robert Postal, Chairman of the Board of Trustees, wrote to Dr. Gordon indicating that the Board

had accepted the Credentials Committee's recommendation of conditional reappointment. Postal, again, requested that Dr. Gordon indicate his willingness to abide by the Conditions of Reappointment. On November 14, 1996, Dr. Gordon signed a document stating, "I accept the above conditions relative to my reappointment and renewal of privileges at Lewistown Hospital and intend to be legally bound thereby." (Def. Ex. 227(A)(11) at p. 4.)

At issue in the instant litigation are Paragraphs 2 and 3 of the Conditions for Reappointment, which required the following:

> (2) You [Dr. Gordon] must use appropriate administrative channels to register *any complaint or concern that you might have about others practicing at the Hospital. Specifically, any complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Credentials Committee, with a copy to the President of the Hospital.* Any complaint or concern about any nursing personnel shall be reported in writing to that individual's supervisor, with a copy to the President of the Hospital. Any other complaint or concern about scheduling, equipment or any other matter must be in writing directed to the President of the Hospital;
>
> (3) *You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician.* Furthermore, other than in response to a specific question or for the purpose of a referral, you

> shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

(*Id.* (emphasis added).)

Dr. Gordon contends that these two paragraphs constitute an unreasonable restraint on trade. The court, however, finds that Conditions 2 and 3 were reasonable in light of Dr. Gordon's past conduct and did not impermissibly restrain trade in any relevant antitrust market at issue in this case.[9]

5. The Gordon/Nancollas Advertising War

Throughout the 1990s, both Dr. Gordon and Dr. Nancollas placed several newspaper ads about their respective practices in the Lewistown Sentinel and other periodicals circulated in Mifflin and Juniata Counties, Pennsylvania. On September 24, 1993, the Geisinger Group placed an ad stating that Dr. Nancollas performed "modern cataract extraction," despite the fact that, at that time, Dr. Nancollas was performing ECCE exclusively. (Pls.Ex. 26.) In another ad, dated August 17, 1995, Geisinger indicated that Dr. Nancollas provided "24 hour local emergency coverage."[10] (Pls.Ex. 43.) These ads also indicated that Dr. Nancollas was a "fully licensed

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[9] *See infra* at Part II.A.2.

[10] Dr. Gordon contends that this statement was false. However, he is incorrect. When Dr. Nancollas was unavailable to cover emergency calls, Dr. Kleinert, a Geisinger ophthalmologist in State College, Pennsylvania, would cover Dr. Nancollas' calls.

ophthalmologist."[11] (Pls. Exs. 26 and 43.) The August 17th ad ran subsequent to an ad by Dr. Gordon touting his multiple board certifications.

In response to what he perceived as false advertising, Dr. Gordon placed an ad in the Lewistown Sentinel on January 12, 1995. In that ad, Dr. Gordon compared himself to Dr. Nancollas and admonished readers to call the Hospital for information regarding a comparison of complication rates between the two. On January 13, 1995, Whitcomb responded by explaining to Dr. Gordon that he believed release of such information was unlawful and that Dr. Gordon should refrain from making such a recommendation in any future advertisements. The Hospital, however, took no disciplinary action against Dr. Gordon for this advertisement.

Dr. Gordon ran another comparative ad on September 15, 1995. That ad contained the headline "We're confused about some recent advertising." (Pls.Ex. 44.) In the ad, Dr. Gordon criticized "the Geisinger ophthalmologist," pointing out the various benefits of the phaco procedure over "the older procedure." (*Id.*) The ad also stated that "100% of the anesthesiologists at Lewiston [sic] Hospital have

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[11] Although this statement also appeared in an advertisement placed during the summer of 1991 – before Dr. Nancollas obtained his certification from the American Board of Ophthalmologists – the statement was not false. Dr. Nancollas was licensed as a medical doctor at that time. Possession of a state medical licence is the only prerequisite to practice ophthalmology. The advertisement did not indicate in any way that Dr. Nancollas possessed a board certification. Moreover, as of November of 1991, Dr. Nancollas was certified by the American Board of Ophthalmologists. (*See* Tr. (Nancollas) at 508-509 ("Q: Dr. Nancollas, you are currently Board certified by the American Board of Ophthalmologists correct? A: Yes. Q: You became Board certified in November of 19917 A: Yes.").)

stated that they would prefer the newer anesthetic technique not yet performed by Geisinger-Lewistown if they were to have cataract surgery." (*Id.*)

Both Geisinger and Dr. Nancollas complained to Whitcomb about Dr. Gordon's advertising campaign. Whitcomb responded that insofar as the September 15th ad referenced the preferences of anesthesiologists at the Hospital, he would forward the matter to the Credentials Committee for investigation as to the statement's truth. However, "the hospital did not feel it appropriate to become involved in a matter between two parties that were external to the hospital if the hospital wasn't implicated in any way." (Tr. (Whitcomb) at 1812.) As a result, the Hospital took no action against Dr. Gordon for this ad, although Whitcomb did express his displeasure to Dr. Gordon regarding the ad's confrontational tone.[12]

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[12] In relevant part, the body of this letter reads as follows:

> Dear Dr. Gordon:
>
> I am writing to indicate the Hospital's concern and displeasure regarding the continued advertising for which you are responsible in [sic] local media.
>
> * * *
>
> *It is recognized that you have the right to place such advertisements and to control the content thereof.* The general feeling I am expressing at the request of members of our Board is objection to the adversarial and unprofessional tone prevalent in your advertisement. Members of the Board and others with whom I come in contact are increasingly expressing disappointment that the advertisements seem to be personal in nature, are unprofessional in content, *and seem to be provoking a negative reaction among the general public. There is growing concern that these advertisements reflect poorly on the medical profession in general, on you in particular and on the Hospital as well.*

(Pls. Ex. 173 (emphasis added).)

The Conditions of Reappointment did not prohibit Dr. Gordon from advertising. Although they did prohibit Dr. Gordon from calling other physician's patients for the purpose commenting about the physician or his surgical method, neither Condition 2 nor 3 prevented Dr. Gordon from advertising the benefits of *his* surgical method. In fact, Dr. Gordon placed at least two ads in the Lewistown Sentinel – on May 1, 1997 and on September 16, 1997 – after the Hospital imposed the Conditions of Reappointment. In the second ad, Dr. Gordon pointed out the increased risks of Dr. Nancollas' procedure without referring to him by name or as "the Geisinger physician." The Hospital took no disciplinary action against Dr. Gordon as a result of these ads.

6. The Hospital Revokes Dr. Gordon's Privileges.

a. The June 4, 1997 Letter

On June 4, 1997, Dr. Gordon composed a letter containing a five-paragraph critique of Dr. Nancollas' surgical method. Specifically, the letter complained of the following: (1) the type anesthesia that Dr. Nancollas uses; (2) the longer duration of Dr. Nancollas' procedures; (3) the length of Dr. Nancollas' incision; (4) stroke risks associated with Dr. Nancollas' incision and manner of administering anesthesia; and (5) allegedly unnecessary risks associated with Dr. Nancollas' use of the phacoemulsifier.[13]

Despite Condition 2's requirement that "any complaint or concern about any other member of the Medical-Dental

[13] By the Spring of 1997, Dr. Nancollas had begun to switch to phaco.

Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Credentials Committee, with a copy to the President of the Hospital," Dr. Gordon distributed the letter to over thirty people. (Def.Ex. 227(A)(11).) He mailed the letter to all members of the Board of Trustees, the Credentials Committee, and the entire Administration. The letter was also copied to Phyllis Palm, the Hospital's Senior Vice President, Dr. Edward Ridings, President of the Medical-Dental Staff, Dr. Everhart, and Margaret Dudick, the Operating Room Supervisor. This letter marked the first time that Dr. Gordon had filed a formal written complaint with the Hospital regarding Dr. Nancollas' competency. Because Dr. Gordon had raised a concern regarding the quality of care at the Hospital, the Credentials Committee initiated a quality study of Dr. Nancollas' procedure. The quality study concluded that Dr. Nancollas' procedure fell within the applicable standard of care and did not expose his patients to an unnecessarily elevated risk level. However, that study was limited only to the difference in operating room time used and the amount of energy expended by the phacoemulsifier during Dr. Nancollas' operations.

b. The Margaret Seecora Phone Call

On July 22, 1994, upon a referral from her optometrist, Dr. Gordon examined Margaret Seecora. During this appointment, Dr. Gordon discovered that Seecora had newly-forming cataracts in both eyes. Dr. Gordon told her about the option of cataract surgery, which she declined at that time. Dr. Gordon saw Seecora twice after that, with the last appointment occurring sometime in September of 1994.

During the period from 1995 through 1997, Dr. Gordon's office placed regular calls to Seecora regarding her eye condition. In response to a solicitation from Dr. Gordon's office in August of 1996, Seecora indicated that she was doing well and that she was seeing her eye doctor. In April, 1997, Dr. Gordon's office called Seecora again. She, however, declined to make an appointment, explaining that she was taking care of her condition.

In March of 1997, Dr. Nancollas performed cataract surgery on Seecora. On Sunday June 27, 1997 – almost three years after he had last examined her – Dr. Gordon called Seecora at her home. During the course of this conversation, Seecora indicated that Dr. Nancollas had removed one of her cataracts. Dr. Gordon contends he was not aware of this when he called Seecora. Yet, despite Condition 3's pellucid command that Dr. Gordon was not to "call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician," Dr. Gordon did not terminate the phone call when he learned of Seecora's association with Dr. Nancollas. (Def.Ex. 227(A)(11).) Instead, Dr. Gordon proceeded to take the opportunity to trash Dr. Nancollas to one of his patients. Dr. Gordon told Seecora that "Nancollas was just learning." (Def. Ex. 556 at p. 31.) Dr. Gordon also suggested that Dr. Nancollas had misled Seecora because he "sometimes doesn't tell the whole story." (Def.Ex. 227(E) at ¶ II.B.) Seecora felt intimidated by the phone call. She also felt that Dr. Gordon was trying to solicit her to use him to remove her remaining cataract. On June 30, 1997, Jean Eckley, Seecora's daughter, telephoned Shirley J. Gates, an administrative

assistant to Palm. During that conversation, she complained about Dr. Gordon's harassing phone call to her mother.

c. The Hospital's Decision to Revoke Dr. Gordon's Privileges

On July 15, 1997, Dr. Everhart requested that Dr. Gordon meet with the Credentials Committee to discuss the Seecora call and the June 4, 1997 letter. Dr. Gordon and his attorney met with the Credentials Committee on July 17, 1997. The next day, Dr. Everhart wrote a letter to Dr. Gordon, informing him of the Committee's unanimous finding that he had violated paragraphs 2 and 3 of the Conditions of Reappointment. That letter also indicated that, effective July 23, 1997, Dr. Gordon would be excluded from the Hospital, his credentials would be revoked, and he would be ineligible to reapply for privileges for a period of at least five years.

On August 22, 1997, at Dr. Gordon's request, a neutral arbitrator held a hearing to address the Credentials Committee's recommendation. On September 25, 1997, the arbitrator issued a Recommendation and Report affirming the Credential Committee's decision to revoke Dr. Gordon's staff privileges. Dr. Gordon requested appellate review of the arbitrator's decision. On November 24, 1997, the Appellate Review Panel issued a Recommendation and Report agreeing with the arbitrator's conclusions. On November 25, 1997, the Board informed Dr. Gordon that it had adopted the Credentials Committee's recommendation.

E. *The Hospital's Allegedly Predatory Tactics*

Plaintiffs contend that the Hospital conspired with Dr. Everhart to gag Dr. Gordon and ultimately to revoke his privileges. According to Plaintiffs, the Hospital took this course of action to placate Geisinger, an important business partner of the Hospital who had become incensed by Dr. Gordon's comparative advertising campaign. Additionally, Plaintiffs contend that the Hospital sought to prevent Dr. Gordon from opening an independent outpatient surgical center which would compete with the Hospital in the market for outpatient facilities services and that the Hospital enlisted Dr. Everhart's assistance in this endeavor.

1. The Hospital's Relationship with Geisinger

a. The Medical Office Building Lease

Geisinger is a corporation that operates a hospital in Danville, Pennsylvania and employs various physician groups at other hospitals located throughout the Commonwealth through its various managed care health plans. The Geisinger health plans are all closed-panel plans. That is, for Geisinger to reimburse charges that patients incur, a Geisinger physician must treat the patient. Dr. Gordon is not a Geisinger physician and has been denied admission into that panel on numerous occasions.

In 1983, Geisinger and the Hospital began a relationship by adopting an "Understanding of Issue Resolution." That document indicated "that any transaction should benefit all parties involved," and that the Hospital would not take any action to obtain additional physician services without first giving Geisinger the right to respond. (Pls.

Ex. 2 at ¶¶ 5 and 12.) It was pursuant to this policy that the Hospital added Dr. Nancollas to the Medical-Dental Staff.

By Fiscal Year ("FY") 1999, Geisinger had become a significant business partner of the Hospital. Geisinger physicians accounted for a substantial share of the Hospital's reimbursement charges. For example, an internal memorandum, generated by the Hospital's administration, indicated that in FY 1999, the Geisinger Health Plan provided 16.9% of the Hospital's total net patient revenue, the largest single private managed care payer of the Hospital's reimbursement charges.

Geisinger was also the largest lessee of space at the Hospital's Medical Office Building, located adjacent to the Hospital campus. Geisinger paid the Hospital over $400,000 a year for this space. Geisinger could terminate the lease by giving the Hospital six months notice before October 31 of 1992, 1997, or 2002. Absent such notice, the lease would renew for another five-year term.

Dr. Gordon makes much of the fact that the Geisinger lease at the Medical Office building was up for renewal during the same year that the Hospital revoked his privileges. Yet, in contrast to his assertions, each and every member of the Hospital staff who testified at trial indicated that there was no mention of Dr. Gordon or his ongoing conflict with the Hospital at any point during the negotiations of the lease renewal. The court finds these witnesses more credible than Dr. Gordon. *See infra* at Part I.G. Accordingly, the court finds that the relationship between the Hospital and Geisinger played no part in the Hospital's decision to revoke Dr. Gordon's privileges.

b. Efforts to Recruit Other Ophthalmologists

According to Plaintiffs, the Hospital has been successful in its effort to deliver the market for ophthalmological physician services in the relevant geographic market to Geisinger by foreclosing Dr. Gordon from these markets. Plaintiffs aver that the Hospital has assisted Geisinger in maintaining its control of these markets by not recruiting any ophthalmologists to compete with Dr. Nancollas.

However, the Hospital attempted on numerous occasions to recruit an ophthalmologist to replace the vacancy created by Dr. Gordon's exclusion. For example, Gordon McAleer, who replaced Whitcomb as Hospital President, attempted to induce Dr. David Werner and his partner – who practice in State College, Pennsylvania – to apply for staff privileges at the Hospital. They declined the invitation, mainly, because they were aware of the instant litigation and did not want to become embroiled in it.

Palm attempted to recruit Dr. David Ludwick, an ophthalmologist practicing in Harrisburg, Pennsylvania, to apply for staff privileges at the Hospital. Her efforts were successful and in October of 1998, the same month Dr. Gordon opened MCCSC, Dr. Ludwick's application was approved. Dr. Ludwick, however, never treated any patients at the Hospital and did not apply for reappointment when his original privileges expired. McAleer also unsuccessfully attempted to recruit Dr. Louis Betz, an ophthalmologist practicing in Lewisburg, Pennsylvania. Dr. Betz refused the invitation because, among other reasons, he feared Dr. Gordon's litigious nature.

The evidence presented at trial cuts against Dr. Gordon's contention that the Hospital does not wish to

recruit a replacement ophthalmologist to compete with Dr. Nancollas. Because the Hospital is located in a fairly remote, rural, sparsely populated area of Pennsylvania, it is not uncommon for it to have only one physician on staff for a particular surgical specialty. There are currently five or six such specialties at the Hospital. More fundamentally, there is no credible evidence that the Hospital has not maintained an open staff – such that any interested and qualified ophthalmologist could apply for staff appointment and clinical privileges – either to placate Geisinger or for any other reason.

2. Dr. Everhart's Surgical Center

Various medical surgeries, including cataract surgery, are often performed in either a hospital setting or in a free-standing outpatient surgery center [hereinafter "surgery center" or "surgi-center"]. In November of 1995, the only outpatient surgical facilities located in Mifflin and Juniata Counties were the Hospital and an outpatient surgery center owned by Dr. Everhart the Endoscopy Center of Pennsylvania, Inc. ("the Endoscopy Center"). Up until 1996, Pennsylvania law required that, prior to opening a new hospital or outpatient surgical center, the Commonwealth had to issue the owner a "Certificate of Need" ("CON"), indicating that an unfulfilled need existed for additional medical facilities services in the proposed facility's service area. Absent the issuance of a CON, no new medical facilities could be opened.

In November of 1995, the Endoscopy Center, which possessed a CON, was only used to perform outpatient endoscopic procedures. Yet, Dr. Gordon asked Dr. Everhart for permission to perform outpatient cataract surgery at

the Endoscopy Center. Dr. Everhart refused. At trial, Dr. Everhart stated several justifications for his decision. First, the Endoscopy Center did not have a CON for ophthalmic surgery. Second, Dr. Everhart's business plans did not include expanding into this area. Third, Dr. Everhart was concerned about Dr. Gordon's litigiousness.[14] Fourth, Dr. Everhart felt that Dr. Gordon mistreated nursing staff and that his presence at the Endoscopy Center would demoralize the staff. The Hospital took no steps to influence Dr. Everhart's decision.

During 1996, Dr. Everhart, the Hospital, and Dr. Gordon all filed CON applications with the Commonwealth. Dr. Everhart sought to expand the Endoscopy Center from a single specialty outpatient surgery center to a multi-specialty surgery center. However, Dr. Everhart was not planning on expanding into ophthalmology. The Hospital itself sought to open its own outpatient surgical center. Finally, Dr. Gordon, fed up with what he perceived as unfair limitations on his operating room time and equipment purchases, decided to open his own independent free-standing surgery center.

The Hospital formally opposed Dr. Gordon's application for a CON, arguing that the project would "create[] unnecessary operating room capacity. . . . " (Def.Ex. 38.) In addition to its concerns regarding excess capacity, the Hospital also wished to correct false statements Dr. Gordon had made in his CON application regarding the

[14] By this period of time, Dr. Gordon had sued the Hospital various times. Because he was Chairman of the Credentials Committee, Dr. Everhart was privy to this information.

Hospital's operating rooms, equipment, and performance. Dr. Everhart also opposed Dr. Gordon's CON application.

During the course of his application for a CON, the Hospital refused to release any information to third parties regarding Dr. Gordon. However, Dr. Gordon had sued the Hospital previously for releasing confidential peer review materials to third parties. Accordingly, the Hospital refused to release any information regarding Dr. Gordon unless he agreed to sign a form releasing the Hospital from liability arising out of its compliance with information requests from third parties. Dr. Gordon refused to sign the proposed release.

Throughout the summer of 1996, Dr. Everhart and the Hospital engaged in negotiations to form a joint venture to open an outpatient surgery center. Although the parties had prepared a "memorandum of understanding," the negotiations broke down, and no joint venture was ever undertaken. Moreover, Dr. Everhart and Dr. Gordon have never been competitors in either the facilities market or the physician services market. No physician practicing at Dr. Everhart's facility performs any sort of ophthalmic surgical procedures. Thus, Dr. Everhart had no improper motivation to do the Hospital's bidding by imposing the Conditions of Reappointment or by excluding Dr. Gordon.

Finally, there is no evidence that the Hospital ever pressured or instructed Dr. Everhart to impose the Conditions of Reappointment or to exclude Dr. Gordon from the Hospital. Dr. Gordon has an extensive history of making disparaging, and oftentimes dishonest, remarks about Dr. Nancollas and the nursing staff in inappropriate forums. Dr. Gordon also had a history of making inappropriate contacts with Dr. Nancollas' patients. Thus, Dr. Everhart

had ample reasons to impose Conditions 2 and 3. Before signing the Conditions of Reappointment, it was made clear to Dr. Gordon that violation of the Conditions could result in the loss of his privileges to practice at the Hospital. When Dr. Gordon violated the Conditions, Dr. Everhart and the Credentials Committee took reasonable action in response to Dr. Gordon's persistent intransigence. There is absolutely nothing in this record which would indicate that either Dr. Everhart or the Credentials Committee acted inappropriately. The disparate threads of circumstantial evidence to which Dr. Gordon points cannot be woven into a blanket conspiracy. In short, Dr. Gordon has failed to convince the court that a conspiracy existed between Dr. Everhart and the Hospital to exclude Dr. Gordon from the Hospital.[15]

3. The Transfer Agreement

In December, 1996, the law requiring the CON expired. Yet, the Pennsylvania Department of Health ("DOH") still required that any physician practicing at a surgery center have staff privileges at a hospital. Additionally, DOH regulations required that surgery centers have a transfer agreement with the closest hospital, in case the need for an emergency transfer to a hospital would be required.

Up through 1998, Dr. Gordon had not received approval for the opening of his proposed surgery center. In a letter, dated August 20, 1998 – almost a year after the

[15] The existence of an antitrust conspiracy is a question of fact. *See Weiss v. York Hosp.*, 745 F.2d 786, 814 n. 47 (3d Cir.1984) (citations omitted).

Hospital had excluded Dr. Gordon – Kathleen John, R.N., a DOH representative, highlighted at least eleven deficiencies revealed during an inspection of the proposed surgi-center site. On October 6, 1998, Nurse John sent another letter to Dr. Gordon regarding a second inspection by DOH personnel. Attached to that letter was a twenty-four page document highlighting deficiencies with the application. DOH required that these deficiencies be remedied before opening the proposed facility. Among these, the DOH noted that Dr. Gordon did not have a tra. sfer agreement with the Hospital, the closest hospital to the proposed site. In response, Dr. Gordon submitted a plan of correction. In that document, Dr. Gordon indicated that he had phoned the Hospital Administration requesting that it issue him a transfer agreement by October 14, 1998. Yet, Palm never received any information regarding any such request, much less a written proposed transfer agreement.[16] Nevertheless, on October 3 or 4, 1998, Nurse John had a meeting with Palm regarding the transfer agreement. Immediately after that meeting, Palm had the Hospital's counsel draw up a proposed agreement on Dr. Gordon's behalf. Both Dr. Gordon and the Hospital signed the transfer agreement on October 16, 1998.[17]

By the end of 1998, Dr. Gordon had opened MCCSC, an independent outpatient surgery center. The Hospital did not, in any way, delay the opening of MCCSC. The request for a transfer agreement was not made to the

[16] The court finds that Dr. Gordon was not a credible witness. *See infra* at Part I.G. Accordingly, the court finds that he never made any such request to Palm.

[17] By this date, Dr. Gordon had obtained staff privileges at Holy Spirit Hospital in Camp Hill, Pennsylvania.

Hospital until early October of 1998, and the Hospital drafted and signed that agreement once the matter was brought to its attention by Nurse John. Additionally, as of that date, Dr. Gordon's application was deficient in several aspects which had absolutely nothing to do with the Hospital.

4. Efforts to Discourage Other Physicians from Practicing at MCCSC.

To open a surgery center, it is necessary to have at least one anesthesiologist on staff. Dr. Gordon sought to employ an anesthesiologist practicing at the Hospital to satisfy MCCSC's need. The Hospital, however, had an exclusive contract with all anesthesiologists who had privileges at the Hospital. According to that contract, anesthesiologists practicing at the Hospital were not allowed to practice at any other facility.

As a result, Dr. Gordon had to seek out the assistance of two anesthesiologists practicing in State College: Dr. Denae Powers and Dr. Edward Dench. According to Dr. Powers, Gordon McAleer, who succeeded Whitcomb as Hospital President, approached her at a social event in the summer of 1998, only a few months before Dr. Gordon was set to open MCCSC. During that conversation, McAleer requested that Dr. Powers refrain from practicing at MCCSC because it would be " . . . detrimental to the Hospital. . . . " (Tr. (Powers) at 374.) When Dr. Powers indicated that, despite McAleer's disapproval, she would be assisting Dr. Gordon, McAleer responded, " . . . well isn't that the way competition has become, dog eat dog?" (*Id.* at 375.) Other than this isolated comment during a social event, the Hospital took no other action to discourage Dr. Powers or Dr. Dench from associating with Dr.

Gordon and MCCSC. As of the date of trial, both of these physicians practiced at MCCSC.

Additionally, Dr. Yolanda Cillo, an orthopedic surgeon, testified about McAleer's efforts to dissuade her from practicing at MCCSC. Dr. Cillo was employed as a member of a physicians group which the Hospital subsidized in an effort to bring new specialists to the Lewistown area. Dr. Cillo applied for staff privileges at the Hospital on April 1, 2000. Under federal law, the Hospital was prohibited from requiring that Dr. Cillo practice exclusively at the Hospital. On July 25, 2000, less than four months after applying for privileges to practice at the Hospital, Dr. Cillo applied for privileges at MCCSC.

In August of 2000, almost two years after MCCSC opened, McAleer approached Dr. Cillo to discuss whether she planned to work at MCCSC. She indicated that she did. McAleer then attempted to dissuade her from associating herself with Dr. Gordon. He also indicated, however, that he was powerless to prevent her from doing so. Dr. Cillo subsequently began to treat patients at MCCSC. At some point thereafter, an article about Dr. Gordon's surgery center appeared in a local paper. The article apparently mentioned that Dr. Cillo was treating patients at MCCSC. McAleer then called Dr. Cillo for an explanation as to why she was practicing at MCCSC. According to Dr. Cillo, McAleer " . . . was quite angry, very livid in fact, as to why my name was in that because he thought we had an understanding. . . . " (Tr. (Cillo) at 363.) After that conversation, Dr. Cillo ceased performing surgery at MCCSC.

McAleer, however, never ordered Dr. Cillo to stop practicing at MCCSC. Additionally, he took no adverse

action against Dr. Cillo to punish her for practicing at MCCSC. In late May of 2001, Dr. Cillo stopped practicing at the Hospital and then left the central Pennsylvania area for personal reasons.

F. *Relevant Antitrust Markets*

The following constitute the relevant product markets in this case: (1) outpatient cataract facility services; (2) outpatient cataract physician services; (3) facility services for inpatient eye surgery; (4) facility services for emergency eye surgery; (5) physician services for inpatient eye surgery; and (6) physician services for emergency eye surgery. These are essentially three sets of complementary product markets. Because the product markets are complementary, their geographic market should be identical.

The geographic scope of the markets for outpatient cataract surgery services consist of all hospitals and surgical centers performing outpatient cataract surgery which are located within thirty miles of Lewistown. The geographic scope of the markets for inpatient eye surgery services consist of all hospitals located within fifty miles of Lewistown. The Hospital does not possess market power in either the outpatient cataract surgery facility services market or the market for inpatient eye surgery facility services.

The geographic scope of the markets for emergency eye surgery services consist of Mifflin and Juniata Counties. The Hospital is the only provider of emergency eye surgery facility services in this area. Therefore, it

possesses market power in this antitrust market.[18] The Hospital's actions did not cause anti-competitive effects in any of the relevant antitrust markets in this case.[19]

G. *Dr. Gordon's Credibility*

Dr. Gordon was not a credible witness regarding either his conduct or the Hospital's reaction to it. Dr. Gordon made a material misstatement of fact on his August 15, 1999 application for re-certification to the American Board of Eye Surgery. In that document, Dr. Gordon was asked, "Have your privileges at any hospital or surgical facility been restricted, suspended, withdrawn, or not renewed at any time during the past ten years?" (Def. Ex. 501 at p. 3.) Dr. Gordon replied "Yes." (*Id.*) However, when asked to explain the circumstances and final result of such disciplinary action, Dr. Gordon stated only that he "move [sic] to surgery center." (*Id.*) Dr. Gordon's abrupt characterization of his extensive history of disciplinary problems at the Hospital differs greatly from the reality of the situation. Put bluntly, Dr. Gordon did not merely move from the Hospital to a surgery center. Rather, he was expelled from the Hospital after three suspensions and a violation of his conditional reappointment. His failure to explain this history in any relevant detail indicates an unwillingness to be truthful about his long history with the Hospital. Moreover, the application also asked Dr. Gordon whether "any disciplinary action [has] been taken [against you] by . . . [a] hospital or

[18] For an in depth analysis of the market power issue, *see infra* at Part II.A.1.b.

[19] For an in depth analysis of anti-competitive effects, *see infra* at Part II.A.1.c.

surgery facility, or any other ethics, grievance, quality review and/or professional conduct committee at any time during the past ten years?" (*Id.*) Dr. Gordon replied, "No." (*Id.*) This constitutes a lie and further bolsters the conclusion that Dr. Gordon is unwilling to tell the truth about the Hospital's disciplinary action against him.

Additionally, during trial, evidence was presented indicating the true motivation for the instant action – Dr. Gordon's desire to ruin the Hospital by dragging it through protracted and expensive litigation. In this respect, Dr. Ridings, the current President of the Hospital's Medical-Dental Staff, testified at trial:

> Q: Dr. Ridings, has Dr. Gordon made statements to you regarding his desire and goals with respect to the Lewistown Hospital?
>
> A: Yes, he has.
>
> Q: And what has he said to you, sir?
>
> A: He has told me several times when we were still friendly that his only goal regarding Lewistown Hospital was to cause it to fail and fold and close.

(Tr. (Ridings) Vol 12 at 213.)

Finally, Dr. Gordon's disruptive conduct after his termination is consistent with this goal. For example, the Hospital's Medical-Dental Staff held an off-premises meeting at a local hotel sometime during the latter part of 2001, over four years after the Hospital revoked Dr. Gordon's staff privileges. Although he was not invited because he was not a member of the Medical-Dental Staff, Dr. Gordon showed up at the meeting. He walked in while McAleer was giving a speech. When McAleer finished his

speech, Dr. Wooten, who was running the meeting asked Dr. Gordon if he would leave because he had not been invited to the meeting. Dr. Gordon refused to leave. Thereafter, Dr. Ridings requested that all invitees who wanted Dr. Gordon to leave to stand up. Upon Dr. Ridings' request, all invitees stood. Dr. Gordon insisted that he would not leave. As a result, Dr. Ridings adjourned the meeting, and the entire staff left.

Dr. Gordon has a personal problem with the Hospital and the way he feels they have treated him. As a result, he has demonstrated a willingness to lie about his disciplinary history with the Hospital, a desire to cause the Hospital to fail financially, and a need to disrupt the Hospital's operation when the opportunity presents itself. As a result, Dr. Gordon's testimony regarding his behavior, and the Hospital's reaction to it, cannot be trusted.

H. *Procedural History*

On June 25, 1999, Plaintiffs filed the instant suit against the Hospital and various other entities. On February 2, 2000, Plaintiffs filed an amended complaint against the Hospital only, alleging violations of Sections 1 and 2 of the Sherman Act. *See* 15 U.S.C. §§ 1 and 2. Plaintiffs' amended complaint stated eight causes of action under the Sherman Act. In that document, Plaintiffs alleged five Section 1 causes of action: a contract in restraint of trade (Count I); illegal tying arrangement (Count II); reciprocal dealing (Count IV); boycott (Count V); and exclusive dealing (Count VI). Plaintiffs also alleged three Section 2 claims: attempted monopolization (Count III); and two claims for conspiracy to monopolize (Counts VII and VIII).

After the expiration of the discovery period, the parties filed cross-motions for summary judgment. On May 21, 2001, the court granted summary judgment in favor of Defendants as to Counts I, IV, V, VII, and VIII, setting up a trial on Counts II and III. The parties then filed cross-motions for partial reconsideration of the court's order of May 21, 2001. On August 15, 2001, the court granted in part Plaintiffs' motion for partial reconsideration. Specifically, the court held that it had erroneously included Count I in the list of claims on which the court granted summary judgment in favor of the Hospital. The court also granted in part the Hospital's motion for partial reconsideration, holding that because Plaintiffs' remaining claims against the Hospital arose out of peer review decisions, those claims would not support an award of monetary damages against the Hospital pursuant to the Health Care Quality Immunity Act. *See* 42 U.S.C. §§ 11101(5) and 11111(a).

Accordingly, the only issues left for trial were Counts I, II, and III. Additionally, if the court were to find that the Hospital violated the Sherman Act, the court would also have to determine whether Dr. Gordon was entitled to injunctive relief; principally reinstatement of his privilege to practice at the Hospital.

II. *Discussion*

A. *Count I: Unreasonable Restraint on Trade*

In Count I of the amended complaint, Plaintiffs aver that:

> The Hospital engaged in various contracts, combinations and conspiracies . . . whereby Dr. Gordon was required to enter into a November,

> 1996 gag contract that prevented Dr. Gordon from communicating truthful non-deceptive information to patients relevant to their surgical decisions, including their choice of ophthalmologist, foreclosed Dr. Gordon from supplying services in the relevant physician opthalmic [sic] surgical markets, and created an unreasonable restraint of trade, all in violation of Section 1 of the Sherman [Act], 15 U.S.C. § 1.

(Amend. Compl. at ¶ 47.)

Section 1 of the Sherman Act (hereinafter "Section 1") provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states . . . is declared to be illegal." 15 U.S.C. § 1. In spite of its sweeping language, courts have long held that literal application of Section 1 would render virtually every business arrangement unlawful. *See, e.g., Chicago Bd. of Trade v. United States,* 246 U.S. 231, 238, 38 S.Ct. 242, 62 L.Ed. 683 (1918) ("Every agreement concerning trade, every regulation of trade, restrains. To bind, to restrain, is of their very essence."). Because even beneficial restraints on trade would be prohibited by a literal interpretation of Section 1, that provision has been interpreted as applying only to those contracts or combinations which are "unreasonably restrictive of competitive conditions." *Standard Oil Co. v. United States,* 221 U.S. 1, 58, 31 S.Ct. 502, 55 L.Ed. 619 (1911).

Relying on Supreme Court case law, the Third Circuit has enumerated three different tests to determine whether a business contract, combination, or conspiracy constitutes an unreasonable restraint on trade in violation of Section 1:(1) the traditional rule of reason test; (2) the *per se* test;

and (3) the quick look rule of reason test. *See United States v. Brown Univ.*, 5 F.3d 658, 668-69 (3d Cir.1993). In its memorandum regarding the parties' cross-motions for summary judgment, the court held that the appropriate standard for evaluating the Section 1 claim in this case is the traditional rule of reason test. *See Gordon v. Lewistown Hosp.*, No.1:CV-99-1100, slip op. at 20-21 (M.D.Pa. May 21, 2001) (citing *Orson, Inc. v. Miramax Film Corp.*, 79 F.3d 1358, 1368 (3d Cir.1996) ("The Supreme Court has instructed that vertical restraints of trade, which do not present an express or implied agreement to set resale prices, are evaluated under the rule of reason."); *Pairkh v. Franklin Med. Ctr.*, 940 F.Supp. 395, 401 (D.Mass.1996) ("Given the potential harms and benefits to competition flowing from vertical agreements . . . courts generally apply a rule of reason in deciding whether a particular agreement violates § 1 of the Sherman Act. . . . "); *MHB Distribs., Inc. v. Parker Hannifin Corp.*, 800 F.Supp. 1265, 1268 (E.D.Pa.1992) ("The appropriate standard for reviewing vertical non-price restraints is rule of reason.")).

Pursuant to the traditional rule of reason test, "[t]he plaintiff bears an initial burden . . . of showing that the alleged combination or agreement produced adverse, anti-competitive effects within the relevant product and geographic markets." *Brown Univ.*, 5 F.3d at 668. However, because proof of actual anti-competitive effects is often impossible to make – due to the difficulty of isolating the market effects of challenged conduct – courts allow a plaintiff to present proof of the defendant's market power to satisfy its initial burden. *Id.* (citing *NCAA v. Board of Regents of the Univ. of Oklahoma*, 468 U.S. 85, 110, 104 S.Ct. 2948, 82 L.Ed.2d 70 (1984); *Tunis Bros. Co. v. Ford*

Motor Co., 952 F.2d 715, 727 (3d Cir.1991); and 7 P. Areeda, *Antitrust Law* ¶ 1503, at 376 (1986)).

Once a plaintiff has successfully met its initial burden under the traditional rule of reason, the burden then shifts to the defendant to "show that the challenged conduct promotes a sufficiently pro-competitive objective." *Id.* at 669. If the defendant carries this burden, the plaintiff must prove that the "restraint is not necessary to achieve the stated objective." *Id.* "[T]he finder of fact must decide whether the questioned practice imposes an unreasonable restraint on competition, taking into account a variety of factors, including specific information about the relevant business, its condition before and after the restraint was imposed and the restraint's history, nature, and effect." *State Oil Co. v. Khan*, 522 U.S. 3, 10, 118 S.Ct. 275, 139 L.Ed.2d 199 (1997). In sum, under the rule of reason "the test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Bd. of Trade*, 246 U.S. at 238; *see also Martin B. Glauser Dodge Co. v. Chrysler Corp.*, 570 F.2d 72, 82 (3d Cir.1977) ("The ultimate test of legality, of course, is whether the particular restraint promotes or impairs competition.").

1. Plaintiffs' Initial Burden

Essentially, Plaintiffs allege that the Hospital imposed the Conditions of Reappointment on Dr. Gordon and then excluded him from the Hospital in an effort to placate Geisinger. According to Plaintiffs, these actions constituted unreasonable restraints on trade in that they unreasonably restrained, and ultimately foreclosed, Dr. Gordon from

competing in the physician services markets for outpatient cataract surgery, inpatient eye surgery, and emergency eye surgery. Additionally, Plaintiffs contend that the Hospital sought to prevent MCCSC from competing with it in the facility services market for outpatient cataract surgery.

To meet their initial burden, Plaintiffs must prove the following: (1) concerted action; (2) that produced anticompetitive effects within the relevant product and geographic markets; (3) that the concerted action was illegal; and (4) that it proximately caused an injury to Plaintiffs. *See Mathews v. Lancaster General Hosp.*, 87 F.3d 624, 639 (3d Cir.1996) (quoting *Petruzzi's IGA Supermkts., Inc. v. Darling-Delaware Co.*, 998 F.2d 1224, 1229 (3d Cir.1993)). As stated previously, instead of proving an actual anticompetitive effect, a plaintiff may satisfy its initial burden by proving market power in the relevant product and geographic markets because market power is essentially a "surrogate for detrimental effects." *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 460-61, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986) (citation omitted). For the reasons stated below, the court finds that Plaintiffs have failed to satisfy their initial burden with respect to all relevant antitrust markets except for the market for emergency eye surgery facility services.

a. Concerted Action

"The very essence of a section 1 claim, of course, is the existence of an agreement." *Alvord-Polk, Inc. v. F. Schumacher & Co.*, 37 F.3d 996, 999 (3d Cir.1994). For a Section 1 claim to be valid, "a plaintiff must prove 'concerted action,' a collective reference to the 'contract . . . combination or conspiracy.'" *Siegel Transfer, Inc. v. Carrier*

Express, Inc., 54 F.3d 1125, 1131 (3d Cir.1995) (quoting *Big Apple BMW, Inc. v. BMW of North America, Inc.*, 974 F.2d 1358, 1362 (3d Cir.1992)). "Unilateral action, no matter its motivation, cannot violate [Section] 1." *Edward J. Sweeney & Sons, Inc. v. Texaco, Inc.*, 637 F.2d 105, 110 (3d Cir.1980).

Plaintiffs contend that they established concerted action in two independent ways: (1) through the Conditions of Reappointment themselves; and (2) through the alleged conspiracy between the Hospital and Dr. Everhart. In contrast, the Hospital contends that the Conditions of Reappointment fall outside the purview of the Sherman Act because Dr. Gordon voluntarily agreed to them and Plaintiffs failed to establish the existence of a conspiracy between Dr. Everhart and the Hospital. Finally, the Hospital argues that the court should preclude Plaintiffs from alleging such a conspiracy because they did not mention it in their amended complaint.

i. The Conditions of Reappointment

According to the Hospital, "[t]he Conditions of Reappointment, voluntarily entered into between Plaintiff and Defendant are contractual requirements of which Plaintiff was fully aware and agreed to prior to signing the Conditions of Reappointment. As such these contractual issues are not within the purview of the antitrust laws." (Def. Prop. Conclusions of Law at ¶ 4.)

In support of this argument, the Hospital relies primarily on *Queen City Pizza, Inc. v. Domino's Pizza, Inc.*, 124 F.3d 430 (3d Cir.1997). In that case, the Third Circuit upheld the district court's order granting Domino's motion to dismiss the plaintiffs-franchisees' claims under Section

1 for monopolization, exclusive dealing, and tying. *See id.* at 444. The court held that the plaintiffs' allegation that Domino's had market power over the "market for ingredients, supplies, materials, and distribution services used in the operation of Domino's stores" failed as a matter of law because the plaintiffs had failed to allege a proper product market. *Id.* at 437, 441. The plaintiffs argued that because Domino's franchise agreement required franchisees to use only Domino's-approved products in their stores, the relevant product market was Domino's-approved products and supplies necessary to run a Domino's franchise. The plaintiffs contended that such an agreement fell within the secondary market doctrine announced by the Supreme Court in *Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 112 S.Ct. 2072, 119 L.Ed.2d 265 (1992). In *Kodak,* the defendant forced its customers to obtain service from Kodak for their already-purchased Kodak copiers, thus establishing a secondary market of captive consumers. In rejecting the Domino's franchisees' argument that the Domino's franchise agreement established a secondary market of captive consumers, the Third Circuit distinguished the situation from *Kodak,* in part, based on the fact that the plaintiffs in *Queen City* voluntarily entered into the contract with Domino's fully aware that Domino's would require it to purchase supplies and materials from it.

> *Kodak* is distinguishable from the present appeal in other important respects. The *Kodak* case arose out of concerns about unilateral changes in Kodak's parts and repairs policies. When the copiers were first sold, Kodak relied on purchasers to obtain service from independent service providers. Later, it chose to use its power over the market in unique replacement parts to

> squeeze the independent service providers out of the repair market and to force copier purchasers to obtain service directly from Kodak, at higher cost. Because this change in policy was not foreseen at the time of sale, buyers had no ability to calculate these higher costs at the time of purchase and incorporate them into their purchase decision. In contrast, plaintiffs here knew that Domino's Pizza retained significant power over their ability to purchase cheaper supplies from alternative sources because that authority was spelled out in detail in section 12.2 of the standard franchise agreement. Unlike the plaintiffs in *Kodak,* the Domino's franchisees could assess the potential costs and economic risks at the time they signed the franchise agreement. The franchise transaction between Domino's Pizza, Inc. and plaintiffs was subjected to competition at the pre-contract stage. That cannot be said of the conduct challenged in *Kodak* because it was not authorized by contract terms disclosed at the time of the original transaction. Kodak's sale of its product involved no contractual framework for continuing relations with the purchaser. But a franchise agreement regulating supplies, inspections, and quality standards structures an ongoing relationship between franchisor and franchisee designed to maintain good will. These differences between the *Kodak* transaction and franchise transactions are compelling.

Queen City Pizza, 124 F.3d at 440.

As this review of *Queen City Pizza* reveals, the court's holding in that case had nothing to do with concerted action. The court did not hold, as the Hospital apparently contends, that voluntary contracts do not constitute concerted action for Section 1 purposes. Moreover, such a

holding would stand in stark contrast to long-standing antitrust precedent holding that contracts entered into between parties of unequal bargaining position, *i.e.* vertical arrangements, are subject to antitrust scrutiny. *See, e.g., Albrecht v. Herald Co.,* 390 U.S. 145, 149, 88 S.Ct. 869, 19 L.Ed.2d 998 (1968) ("[Section 1] covers combinations in addition to contracts and conspiracies, express or implied.") (citing *United States v. Parke, Davis & Co.,* 362 U.S. 29, 80 S.Ct. 503, 4 L.Ed.2d 505 (1960)) *overruled on other grounds by State Oil Co. v. Khan,* 522 U.S. 3, 118 S.Ct. 275, 139 L.Ed.2d 199 (1997) (holding that vertical maximum price fixing not subject to *per se* analysis under Section 1 of the Sherman Act). Because the Conditions of Reappointment constituted a contract, the decision to impose them qualifies as concerted action. Therefore, the court finds that Plaintiffs' have satisfied their burden of proving this element.

ii. The Alleged Conspiracy with Dr. Everhart

Additionally, Plaintiffs claim that they established the existence of a conspiracy between the Hospital and Dr. Everhart, its competitor in the outpatient facilities market, which satisfies the concerted action requirement. The Hospital argues that Plaintiffs' claim regarding the alleged conspiracy between Dr. Everhart and the Hospital fails for two reasons. First, the evidence was factually insufficient to support a holding that such a conspiracy existed. Second, Plaintiffs failed to properly allege this conspiracy in their amended complaint.

The court holds that the Hospital's relationship with Dr. Everhart does not satisfy the concerted action requirement of a Section 1 claim. As the court has stated

above, Plaintiffs have not convinced the court that such a conspiracy existed. *See supra* at Part I.E.2. Plaintiffs, however, apparently contend that because the existence of the ultimately-unsuccessful joint venture arrangement between the Hospital and Dr. Everhart is undisputed, they have met their burden and are not required to prove that either the Hospital or Dr. Everhart coerced the peer review process to injure Dr. Gordon. (*See* Pls. Supp. Proposed Findings of Fact at ¶ 13 ("Moreover, the Hospital's coercion of Dr. Everhart is irrelevant.").)

In *Mathews v. Lancaster General Hospital,* however, the Third Circuit stated that "[w]here a hospital board has ultimate decision making authority, '[s]imply making a peer review recommendation does not prove the existence of a conspiracy [among the hospital and its staff]'; there must be something more such as a conscious commitment by the medical staff to coerce the hospital into accepting its recommendations." 87 F.3d at 639 (quoting *Oksanen v. Page Mem'l Hosp.,* 945 F.2d 696, 706 (4th Cir.1991)). Of course, the converse of that statement is true as well. That is, where it is the hospital that has allegedly manipulated the peer review process, there must be some evidence of coercion. In this respect, Plaintiffs presented evidence that Dr. Everhart and the Hospital were contemplating a joint venture at approximately the same time that the Hospital was in the process of imposing the Conditions of Reappointment on Dr. Gordon. While "a contractual relationship might support an inference" of coercion, the court does not find that coercion occurred in this case. *Id.* at 640. Given that the compelling evidence in this case vindicates the reasonableness of the Credentials Committee's actions, regardless of their antitrust consequences, the court will not impute an anti-competitive motive to Dr. Everhart's

conduct.[20] In short, there is no compelling evidence indicating that Dr. Everhart or the Hospital manipulated the peer review process at all, much less to injure Dr. Gordon or competition among physicians. Thus, the court finds that Plaintiffs have failed to prove concerted action between Dr. Everhart and the Hospital. Because the court finds that Plaintiffs failed to meet their burden as to this point, the court need not address the Hospital's argument regarding the deficiency of Plaintiffs' amended complaint in this regard.

b. Market Power

As stated above, a plaintiff in an action brought under Section 1 of the Sherman Act may establish its initial burden of demonstrating that the concerted action actually caused anti-competitive effects. *See supra* at Part II.A.1. However, because "[s]uch proof is often impossible to make . . . courts typically allow proof of the defendant's 'market power' instead." *Brown Univ.*, 5 F.3d at 668 (citations omitted).[21]

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[20] To the extent that Plaintiffs claim that the agreement between Dr. Everhart and the Hospital, which provided that Dr. Everhart's surgery center would not compete with the Hospital in providing a facility for outpatient cataract surgery, constitutes an impermissible market allocation agreement, the court finds that this agreement did not proximately cause Dr. Gordon's alleged injury. Dr. Gordon's conduct caused the imposition of the Conditions of Reappointment and his ultimate exclusion. *See Petruzzi's IGA Supermkts.*, 998 F.2d at 1229 (holding that to satisfy initial burden under rule of reason analysis, the plaintiff must establish not only concerted action, but also that the concerted action proximately caused the plaintiff's injury).

[21] Likewise, to establish a Section 1 illegal tying claim, the plaintiff may satisfy its burden by demonstrating that the defendant possessed market power. *See infra* at Parts II.B.1.

"As an economic matter, market power exists whenever prices can be raised above the levels that would be charged in a competitive market." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde,* 466 U.S. 2, 27 n. 46, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984). It "is essentially a 'surrogate for detrimental effects.'" *Brown Univ.,* 5 F.3d at 668 (quoting *Indiana Federation of Dentists,* 476 U.S. at 460-61).[22] The existence of market power is a question of fact. *Fineman v. Armstrong World Indus., Inc.,* 980 F.2d 171, 199 (3d Cir.1992); *Weiss v. York Hosp.,* 745 F.2d 786, 825 (3d Cir.1984). A plaintiff bears the "affirmative duty of proving the relevant product and geographic markets affected by the defendants' alleged uncompetitive activity." *Eichorn v. AT & T Corp.,* 248 F.3d 131, 147 n. 4 (3d Cir.2001) (citing *Ideal Dairy Farms, Inc. v. John Labatt, Ltd.,* 90 F.3d 737, 743 (3d Cir.1996) (holding that the plaintiff must present evidence from which a rational person could conclude that the relevant markets are what the plaintiff alleges them to be)).

Defining the relevant product and geographic markets is the first step in an analysis of whether a particular firm possesses market power. *See Brokerage Concepts v. U.S. Healthcare,* 140 F.3d 494, 513 (3d Cir.1998) (stating that antitrust markets have two components: product and geographic); (*see also* Tr. (Gaynor) at 1287 ("First step is define the product market, define the

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[22] Alternatively, market power also exists if a firm can profitably maintain lower product or service quality, at the same price, for a significant period of time. (*See* Tr. (Harris) at 2335 (stating that market power also refers to the ability to lower quality, but emphasizing that "it must be profitable. Anyone could set a price higher than the competitive level, but if no [sic] comes to you, then it is not an exercise of market power. That is a bad business decision.").)

geographic market.").) Once the relevant product and geographic markets have been defined, the court must determine if the defendant's market share is sufficient for the court to infer the existence of market power or if other relevant factors – such as the strength of competitors or barriers to entry of competitors – are sufficient for the court to infer market power. *See Fineman,* 980 F.2d at 201-02.

i. Product Market

"'Defining a relevant product market is primarily a process of describing those groups of producers which, because of the similarity of their products, have the ability – actual or potential – to take significant amounts of business away from each other.'" *U.S. Anchor Mfg., Inc. v. Rule Indus., Inc.,* 7 F.3d 986, 995 (11th Cir.1993) (quoting *General Indus. Corp. v. Hartz Mountain Corp.,* 810 F.2d 795, 805 (8th Cir.1987) (internal quotation omitted)); *accord SmithKline Corp. v. Eli Lilly & Co.,* 575 F.2d 1056, 1063 (3d Cir.1978). Plaintiffs claim there are four separate product markets[23] at issue in this case: (1) facility services

[23] Based on testimony provided by Plaintiffs' expert, Dr. Martin Gaynor, it appears that Plaintiffs are alleging that several of these markets are actually submarkets of other broader markets. (*See* Tr. (Gaynor) at 1302.). However, this is a distinction without a difference. Antitrust law treats markets and submarkets the same way. *See Brown Shoe Co. v. United States,* 370 U.S. 294, 325 n. 42, 82 S.Ct. 1502, 8 L.Ed.2d 510 (1962) ("[W]ithin this broad market, well-defined submarkets may exist which, in themselves, constitute product markets for antitrust purposes."). While it is important for the court to determine what exactly are the distinct markets at issue in this case, it does not matter whether those markets are termed markets themselves or whether they are submarkets of each other. Therefore, to avoid

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for inpatient eye surgery; (2) facility services for outpatient cataract surgery in a hospital setting; (3) facility services for outpatient cataract surgery in either a hospital or a free-standing surgery center (also referred to as "general cataract facility services"); and (4) facility services for emergency eye surgery.[24]

The Hospital, on the other hand, contends that there are fewer markets than Plaintiffs allege. Specifically, the Hospital contends that there is only one market relevant to outpatient cataract surgery.[25] That is, there is no

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confusion, the court will refrain from using the term submarket. *But see infra* at fn. 28.

[24] Plaintiffs also contend that there are four additional physician services markets at issue in this case which correspond to the complimentary facility services markets: (1) outpatient cataract physician services in a hospital setting; (2) outpatient cataract physician services in either a hospital or a free-standing surgery center; (3) inpatient eye surgery physician services; and (4) emergency eye surgery physician services. The Hospital, however, is not a participant in the physician services aspects of these markets and, therefore, cannot possess market power in those markets. Moreover, Plaintiffs allegation is that the Hospital leveraged its power in the facility services markets to cause competitive injury in the physician services and facility services markets. Thus, whether the physician services markets are sufficiently well defined is irrelevant to our purposes. The court, therefore, will not discuss these markets in its analysis of market power. However, because these markets are complimentary that is, for each facility services markets there is a corresponding physician services market – any holding regarding the appropriate facility services market would pertain equally to the corresponding physician services market. This is a result of the very nature of eye treatment. Patients will only purchase a facility service along with the corresponding physician service. That is, patients undergoing eye treatment need both a facility in which they can be treated and a physician who will treat them.

[25] The Hospital argues that Plaintiffs have failed to prove several of the other markets as well. However, those objections pertain to the geographic scope of those markets. Those objections are discussed below. *See infra* at Part II.A.1.b.ii.

separate market for outpatient cataract surgery performed in a hospital setting.

"The outer boundaries of a product market are determined by evaluating which products would be reasonably interchangeable by consumers for the same purpose." *Brokerage Concepts,* 140 F.3d at 513. "'Interchangeability' implies that one product is roughly equivalent to another for the use to which it is put; while there might be some degree of preference for the one over the other, either would work effectively." *Allen-Myland, Inc. v. International Business Machines Corp.,* 33 F.3d 194, 206 (3d Cir.1994) (internal quotations omitted). "When assessing reasonable interchangeability, '[f]actors to be considered include price, use, and qualities.'" *Queen City Pizza,* 124 F.3d at 437 (quoting *Tunis Bros. Co., Inc. v. Ford Motor Co.,* 952 F.2d at 726).

Thus, with respect to the relevant product markets, the issue is whether outpatient cataract surgery performed in a free-standing surgery center is reasonably interchangeable with, or substitutable for, outpatient cataract surgery in a hospital. If the two services are reasonably interchangeable, then they are part of the same product market. If not, they each constitute their own product market.

There are, of course, certain patients for whom outpatient cataract surgery in a free-standing surgery center is impossible. For example, Dr. Martin Gaynor, one of Plaintiffs' economic experts testified that, by regulation, children and people requiring general anesthesia may not be treated in a free-standing surgery center. (*See* Tr. (Gaynor)

at 1295.)[26] Also, there are other patients whose physicians require that they receive outpatient surgery in a hospital setting as a matter of medical prudence. However, it is undisputed that these types of patients are exceptional. As a result, their need to have outpatient cataract surgery in a hospital setting is not demonstrative of general patient preference, which is the cornerstone of any sound definition of a product market. (*See* Tr. (Gaynor) at 1296 ("A: . . . But in general, economics says that product markets are determined by what consumers consider to be practical alternatives or substitutes. Q: Does the issue of consumer taste go to the issue of practical alternatives? A: Precisely.")); *see also, Queen City Pizza,* 124 F.3d at 438 ("The test for a relevant market is not commodities reasonably interchangeable by a particular plaintiff, but 'commodities reasonably interchangeable by consumers for the same purposes.'" (quoting *United States v. E.I. du Pont de Nemours & Co.,* 351 U.S. 377, 395, 76 S.Ct. 994, 100 L.Ed. 1264 (1956))).

At trial, Dr. Gaynor concluded that his study of consumer preference indicated that separate markets exist for outpatient cataract surgery in a hospital setting and general outpatient cataract surgery in either a hospital or a free-standing surgery center. He based his conclusion on patient migration and price data. As he testified,

> The idea that motivated this analysis goes as follows: If there are people that either strongly prefer to be treated in a hospital setting . . . then if we look where there are both hospitals and

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[26] Although children may not undergo surgery in a free-standing surgery center, it is beyond dispute that the overwhelming majority of cataract surgery patients are elderly.

> free-standing surgery centers treating cataract surgeries, and we look at places where the price for the hospital is higher than for the free-standing surgery center, and if a substantial number of people still go to the hospital, then it would indicate to me that there are people who . . . have very strong preferences to be treated in a hospital setting. . . .
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> * * *
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> So what I did is the following: I identified all the cities in Pennsylvania that had at least one free-standing surgery center doing cataract surgery and at least one hospital doing cataract surgery, and for which the charges for the hospital were higher than the charges for the facility. . . .
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> * * *
>
> And in half of those cities, 46 percent of the cataract surgery patient[s] go to a hospital, and 54 percent go to a free-standing facility. So in spite of the fact that there are alternatives, both in the same city and one of them has a much higher price, there are a very substantial number of patients who still choose to go to a hospital.
>
> And that is consistent with the notion that there exists a separate product market for hospital cataract – hospital outpatient cataract surgery.

(*Id.* at 1297-98.)

The phenomenon whereby a price increase of a good in a particular market would tend to create greater demand for goods in other markets is what is often referred to as "cross-elasticity of demand." *See, e.g., Tunis Bros.*, 952 F.2d at 722. Taken at face value, Dr. Gaynor's study indicates a lack of cross-elasticity of demand between the markets for

general outpatient cataract surgery and outpatient cataract surgery in a hospital setting. If the court were to accept this argument, then it would be forced to conclude that there are separate markets for these services.

Dr. Gaynor's price-based analysis, however, does not accurately portray whether outpatient cataract surgery in a free-standing surgery center is reasonably interchangeable with outpatient cataract surgery in a hospital. First, price is not an accurate measure of consumer preference in the field of medicine because a majority of the costs incurred are paid by third-party payers such as private insurance companies and Medicare. (*See* Pls. Proposed Findings of Fact at ¶ 35 ("Like all physicians, cataract surgeons compete on many dimensions other than price, including innovation, product variety and product quality. Indeed, because most of the cost of surgery is born by third-party payers, the most meaningful competition among surgeons is on the basis of quality and patient preference [for surgical method or physician].")); *see also FTC v. Tenet Health Care Corp.*, 186 F.3d 1045, 1054 (8th Cir.1999) ("As the district court noted, healthcare decisions are based on factors other than price."); *Urdinaran v. Aarons*, 115 F.Supp.2d 484, 489 (D.N.J.2000) ("Because medical fees are largely dictated by health insurance companies, Medicaid, and Medicare, courts have looked at . . . indicia [other than price] of anticompetitiveness, such as quality of care, which is often determinative for consumers of medical services."). Without evidence that third-party payers would steer their patient's choices based on the price of the facility where the procedure is performed, Dr. Gaynor's study does not validly demonstrate a consumer recognition of distinct markets for facility and physician services for outpatient cataract surgery in a

hospital setting. *But see FTC v. Freeman Hosp.*, 69 F.3d 260, 270 n. 14 (8th Cir.1995) (holding that evidence indicating that third-party payers would only steer patients elsewhere in reaction to a 15 to 20% increase "should be given some weight, since the terms of managed care and third-party insurance contracts necessarily have some bearing on where patients can practicably turn for their health care.").

Second, outpatient cataract surgery in a surgical center is functionally equivalent to outpatient cataract surgery in a hospital setting. A physician will perform the exact same procedure in both settings, and the patient will receive the same result. Neither the surgical method employed, nor the outcome of the surgery, depends on the facility in which it is performed. (*See* Tr. (Burns) at 2132 ("Q: Dr. Burns have you ever hesitated to offer Dr. Gordon as an option to one of your patients for cataract surgery because of the fact that he performs surgery in a surgicenter as opposed to a hospital? A: No.").)

Based on the foregoing, the court will not accept Dr. Gaynor's conclusion that there are separate markets for outpatient cataract surgery performed in a hospital setting and general outpatient cataract surgery. The truth is, except for the very limited class of patients who cannot be treated in a surgery center or whose physicians would counsel against it, the use and quality of the outpatient cataract surgery are the same regardless of the type of facility in which it is performed. As a result, suppliers of outpatient cataract facility services in a free-standing

surgery center are effective competitors with suppliers of outpatient cataract facility services in a hospital setting.[27]

The evidence presented at trial supports this conclusion. For example, in 1999 – the first full calendar year that MCCSC was open – Dr. Gordon performed 945 "Gordon/Nancollas" procedures for patients residing in the Hospital's primary service area, all at a free-standing surgery center. That same year, Dr. Nancollas performed only 162 such procedures, all at the Hospital. (Def.Ex. 547, Ex. 18.)[28] Such a staggering contrast in the output between these competitors sharply contradicts Plaintiffs' contention that consumer preference indicates that distinct markets exist for outpatient cataract surgery performed in a hospital setting. Instead, this evidence indicates that patient preference is driven much more by quality concerns – affinity for a particular physician or a desire to have a particular surgical method used – than by the setting in which the surgery is performed.[29] The evidence

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[27] The same holds true in the proposed complementary markets for physician services.

[28] Although these numbers include other forms of outpatient ophthalmic surgery, outpatient cataract surgery accounted for over 95% of these procedures. (*See* Tr. (Harris) at 2346 ("I looked at what I call Gordon/Nancollas procedures. And that was the set of procedures performed by Dr. Gordon and Dr. Nancollas. It was overwhelmingly in excess of 95 percent cataracts, but it included a few other procedures as well.").)

[29] Although Dr. Gaynor testified at trial that the disparity between Dr. Gordon's procedures and Dr. Nancollas' procedures in 1999 resulted from the release of pent-up demand, this tends to further undercut Dr. Gaynor's conclusion regarding consumer preference. The pent-up demand resulted because patients viewed Dr. Gordon as a better surgeon than Dr. Nancollas. This confirms that quality, not setting, is what truly drives consumer choice in the context of outpatient cataract surgery facility and physician services.

did not indicate that patients differentiate outpatient cataract surgery performed in a free-standing surgery center from the same procedure performed in a hospital setting.[30]

Another of Plaintiffs' experts, Dr. William Vogt, Ph.D., testified that the number of patients Dr. Gordon treated after opening MCCSC was 29% lower than the number of patients that Dr. Vogt had predicted, using population and demographic data, Dr. Gordon should have treated. According to Plaintiffs, this demonstrates that a separate market for hospital-based outpatient cataract surgery existed. However, this demonstrates only that Dr. Gordon may have suffered an economic injury as a result of his exclusion from the Hospital, not that a separate product

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[30] As a brief matter of clarification, outpatient cataract facility services in a hospital setting would likewise not qualify as a distinct submarket of the general market for outpatient cataract facility services. First, there is no industry recognition of these services as constituting separate economic entities from the general market for outpatient cataract surgery facility services. Second, there is no peculiar characteristic of outpatient cataract surgery performed in a hospital setting. Third, there are virtually no specialized vendors who exclusively market themselves as providing facility services for outpatient cataract surgery in a hospital setting. Fourth, while there are distinct prices for such services depending on whether they are performed in a hospital or a free-standing surgery center, price is not relevant where, as here, the cost is usually borne by third party payers and not consumers. Fifth, for the same reason, there is little to no sensitivity to price changes. Sixth, a hospital setting is not a unique production facility because the same result can be obtained if the surgery is performed in a free-standing surgery center. Seventh, there are some distinct customers who must, or should, undergo outpatient cataract surgery in a hospital setting. However, the number of these patients is so small that they are not a reliable indicator of consumer preference. *See Brown Shoe Co.*, 370 U.S. at 325, 82 S.Ct. 1502 (listing seven factors in determining whether a submarket exists). The same holds true for the complimentary physician services market.

market exists for outpatient cataract surgery performed in a hospital setting. Because antitrust law is concerned with injury to competition, not competitors, such information is of limited assistance in defining the relevant product markets. *See Mathews v. Lancaster Gen. Hosp.*, 87 F.3d at 641 ("'An antitrust plaintiff must prove that challenged conduct affected price, quantity or quality of goods or services,' not just his own welfare." (quoting *Tunis Bros.*, 952 F.2d at 728)). Thus, Dr. Vogt's statistics regarding injury to a competitor within a narrowly-defined geographic market bears little on the question of whether outpatient cataract surgery in a hospital setting or a free-standing surgery center are functionally equivalent. Even if the court were to accept Dr. Vogt's statistical analysis, alone, this would not convince the court that a separate market exists for outpatient cataract surgery performed in a hospital setting, given the extensive information indicating that the two settings are functional equivalents. *See supra.*

In summation, the court finds that there is only one general market for outpatient cataract surgery facility services, as opposed to the separate markets – espoused by Plaintiffs – for outpatient cataract surgery generally and outpatient cataract surgery performed in a hospital setting. Additionally, there are two other relevant product markets at issue in this case: facility services for inpatient eye surgery; and facility services for emergency eye surgery.

ii. Geographic Markets and Market Share

Having determined the relevant product markets, the court must now determine, for each of these markets,

whether Plaintiffs have satisfied their burden of establishing the geographic scope of these product markets, as well as the Hospital's share. "The relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks. . . . " *Pennsylvania Dental Ass'n v. Medical Serv. Ass'n of Pa.*, 745 F.2d 248, 260 (3d Cir.1984) (citing *United States v. Grinnell Corp.*, 384 U.S. 563, 570-71, 86 S.Ct. 1698, 16 L.Ed.2d 778 (1966)); *accord Surgical Care Ctr. v. Hospital Serv. Dist.*, 309 F.3d 836, 840 (5th Cir.2002) (quoting *Doctor's Hosp. of Jefferson No. 2 v. Southeast Med. Alliance,* 123 F.3d 301, 311 (5th Cir.1997)); *Borough of Lansdale v. Philadelphia Elec. Co.*, 692 F.2d 307, 311 (3d Cir.1982) (quoting *Morton Bldgs. of Nebraska, Inc. v. Morton Bldgs., Inc.*, 531 F.2d 910, 918 (8th Cir.1976)). "The relevant . . . geographic market must reflect the realities of competition." *Doctor's Hosp.*, 123 F.3d at 311; *accord Oksanen v. Page Mem'l Hosp.*, 945 F.2d at 709. The geographic scope of a relevant product market is a question of fact and is "to be determined in the context of each case in acknowledgment of the commercial realities of the industry under consideration." *Borough of Lansdale,* 692 F.2d at 311 (citing 2 E. Kintner, Federal Antitrust Law § 12.4 (1980)). Determining the breadth of the geographic market is important because it establishes the area in which the court will calculate the defendant's market share in the relevant product market(s). *See Miller v. Indiana Hosp.*, 814 F.Supp. 1254, 1262 (W.D.Pa.1992) ("It is the geographic region in which a purchaser can practically turn to other sellers for products or services, in the event that the defendant seeks to raise prices or reduce output."). With this standard in mind, the court will now determine whether Plaintiffs have met their burden of proving the

geographic scope of the relevant product markets at issue in this matter.

-Outpatient Cataract Facility Services

Plaintiffs contend that the evidence conclusively establishes that the geographic scope of the outpatient cataract facility services market is Mifflin and Juniata Counties. Because, prior to the opening of MCCSC, the Hospital was the only facility in this geographic region where patients could receive outpatient cataract surgery, Plaintiffs contend that the Hospital's decisions to suspend Dr. Gordon, to impose the Conditions of Reappointment, and ultimately to revoke his privileges, are properly viewed as exercises of market power. According to Plaintiffs, these decisions allowed the Hospital to drastically reduce output, supply, and product quality in this geographic area by forcing patients to either use the Hospital or to forego cataract surgery altogether. To support their conclusion that Mifflin and Juniata Counties comprise the relevant geographic market, Plaintiffs introduced the following types of evidence: (1) geographic characteristics of the Mifflin and Juniata Counties region; (2) the types of patients who need cataract surgery; (3) the process patients go through when getting cataract treatment; (4) patient flow data indicating where patients go to have their cataracts treated; (5) statements by the Hospital; and (6) the views of market participants concerning the realities facing patients.

According to Plaintiffs, "[l]arge mountain ranges separate the residents of Mifflin County and Juniata County from other hospitals and surgery centers that provide cataract facility [and physician] services." (Pls.

Prop. Findings of Fact at ¶ 158.) Additionally, cataract patients are almost always elderly and tend to dislike traveling distances. Moreover, the cataract condition limits the patient's ability to drive, making it more likely that those patients would choose to have their surgery procedure performed locally, rather than opt to travel outside Juniata and Mifflin Counties to hospitals or surgical centers located beyond the mountain ranges.

To bolster this contention, Dr. Gaynor testified about his analysis of patient migration data using the Elzinga-Hogerty test. This test was developed by professors of economics Kenneth G. Elzinga and Thomas F. Hogerty "to analyze patterns of consumer origin and destination and to identify relevant competitors" in a particular geographic location. *FTC v. Freeman Hosp.*, 69 F.3d at 264 (citing *United States v. Rockford Mem'l Corp.*, 717 F.Supp. 1251, 1266 (N.D.Ill.1989)). In theory, the Elzinga-Hogerty test measures not only the geographic contours of the market area, but whether a firm or firms has market power in that area. The test consists of two separate measures – LIFO (or "little in from the outside") and LOFI (or "little out from the inside"). "In the hospital context, a Lofi . . . statistic signifies the percentage of patients in an area's hospitals who reside in the area (rather than outside the area)." *Rockford Mem'l Corp.*, 717 F.Supp. at 1266. "A 'Lifo' . . . statistic signifies the percentage of hospital patients from a particular area who remain in that area for hospital services. . . . This statistic is useful in determining whether patients in a particular area make substantial use of hospitals outside the area." *Id.* (citations omitted). A well defined market will highlight a geographic area in which few patients leave to seek treatment at facilities outside the area and few patients come from outside the

area to have treatment performed at facilities located inside the area. *Id.* at 1267.

The Elzinga-Hogerty test suggests two standards which speak to the proportion of consumers who flow in and out of a particular area. One standard, is referred to as a "weak market," which constitutes a market in which no more than 25% of consumers from the area are flowing out ("LIFO") to other facilities and no less than 75% of the consumers who purchase the product or service at facilities located in the proposed market come from inside that area ("LOFI"). The "strong market" Elzinga-Hogerty test is met when the LIFO is no more than 10% and the LOFI is no less than 90%. If the patient migration data satisfies either of these standards, it indicates, in economic terms, that the market is geographically well defined and a firm or firms has some degree of market power in the geographic arena.

In calculating his Elzinga-Hogerty analysis of the geographic market for outpatient cataract surgery services, Dr. Gaynor used data compiled by the Pennsylvania Health Care Cost Containment Council ("The PHC-4"). This data listed most patients who underwent outpatient cataract surgery in a particular year, where those patients lived, where the patients underwent surgery, and which doctor performed the procedure. The PHC-4, however, did not begin compiling this data until 1996.[31] Using this data,

[31] Dr. Gaynor did not feel the 1996 data was an ideal period for determining LIFO and LOFI because the Hospital suspended Dr. Gordon twice – the forty-five day suspension and the intervening summary suspension – and imposed the Conditions of Reappointment during that year. Thus, according to Dr. Gaynor, because the Hospital had already engaged in allegedly predatory conduct during 1996, "it is possible that, if anything, that could have artificially inflated the size of

(Continued on following page)

Dr. Gaynor sought to analyze whether the Hospital possessed market power sufficient to accomplish its alleged anti-competitive goals.

Applying the PHC-4 data for 1996, Dr. Gaynor began by calculating the Hospital's share of patients undergoing cataract surgery in a particular zip code and that zip code's percentage contribution to all of the cataract surgeries performed at the Hospital in that year. Dr. Gaynor continued this zip code by zip code analysis, calculating both the zip codes' individual LOFI and LIFO numbers and their cumulative inflow and outflow when combined with data from the other zip codes. Applying this methodology, Dr. Gaynor concluded that a twenty-three zip code area satisfied the criteria for a weak Elzinga-Hogerty market. Patients from this area constituted approximately 84.1% of the Hospital's outpatient cataract patients. Therefore, only 15.9% of the Hospital's cataract patients came from outside this twenty-three zip code area. The Hospital served approximately 77.8% of the outpatient cataract patients in those twenty-three zip codes, meaning that only 22.2% of the patients living in those zip codes

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the geographic market." (Tr. (Gaynor) at 1306.) Dr. Gaynor's conclusion, in this respect, is based on nothing more than mere speculation. According to Dr. Gaynor, "the fact that Dr. Gordon is suspended and people can't see him disrupts the market. Then some people may choose to go elsewhere." (*Id.*) However, without data indicating that patients actually did go elsewhere as a result of Dr. Gordon's suspensions, the court is unwilling to accept Dr. Gaynor's conclusion that the 1996 data would inflate the breadth of the proposed geographic market. Moreover, even if patients fled Mifflin and Juniata Counties for cataract surgery, this would seem to suggest that patients viewed other suppliers of physician services as viable alternatives to Dr. Gordon and Dr. Nancollas. Thus, if this proves anything, it would prove that the geographic market is broader than Dr. Gaynor's Elzinga-Hogerty analysis suggests; not that it was artificially inflated.

went to facilities located outside of the area for outpatient cataract surgery. These twenty-three zip codes consist almost entirely of Mifflin and Juniata Counties.

The Elzinga-Hogerty test, however, has its weaknesses. First, Professor Elzinga has stated that the test is plaintiff oriented. That is, the tests "tend to give markets that are more favorable to plaintiffs, narrower markets than are actually the case." (Tr. (Harris) at 2396.) Second, the test is sensitive to zip code ordering. By ordering zip codes in a particular manner, the test can have the result of excluding producers who are located just outside the geographic fringe of the proposed market.[32] Third, by using an aggregate zip code analysis instead of an individual zip code analysis, the Elzinga-Hogerty test does not examine whether people in particular zip codes actually exercise choice. For all of these reasons, the Elzinga-Hogerty test tends to define geographic markets more narrowly, often excluding realistic competitors located just outside the geographic boundaries of the defined market. Perhaps for these reasons, Professor Elzinga has stated that the strong Elzinga-Hogerty test is the more accurate measure of a well defined antitrust market. The weak market test is just that, a weak indicator of a properly defined geographic market and a firm's market power.

In this case, the data suggested that a weak market existed which covered most of Mifflin and Juniata Counties. The court, however, finds that the weak Elzinga-Hogerty standard unjustifiably disregards the fact that

[32] In fact, when Dr. Gaynor sorted the zip codes according to their importance to the Hospital, the data did not satisfy either of the Elzinga-Hogerty tests. (*See* Tr. (Gaynor) at 1461; *see also* Appendix, Ex. A.)

almost one-quarter of all patients within Mifflin and Juniata Counties were exercising choice in 1996 by having their procedures performed at facilities located outside of the two counties. *See FTC v. Tenet Health Care Corp.*, 186 F.3d at 1053 ("In adopting the FTC's position [based on the Elzinga-Hogerty test], the district court improperly discounted the fact that over twenty-two percent of people in the most important zip codes already use hospitals outside the FTC's proposed market for treatment that is offered at Poplar Bluff hospitals."). Moreover, by focusing on what patients were doing in 1996 – not what patients could have done in the event the Hospital attempted to lower quality or output – the Elzinga-Hogerty analysis does a disservice to the purpose of conducting a geographical analysis of the market's breadth: identifying realistic substitute suppliers. *See Surgical Care Ctr.*, 309 F.3d at 840 ("Absent a showing of where people could practicably go for inpatient services, St. Luke's failed to meet its burden of presenting sufficient evidence to define the relevant geographic market."); *Eichorn v. AT&T Corp.*, 248 F.3d 131, 247 (3d Cir.2001) ("By defining the market so narrowly that it only includes the defendants, plaintiffs' proffered geographic and product markets are unrealistic."); *Tenet Health Care*, 186 F.3d at 1052 ("This evidence must address where consumers could practicably go, not on where they actually go."); *Doctor's Hosp.*, 123 F.3d at 311 ("Critically, evidence must be offered demonstrating not just where consumers currently purchase the product, but where consumers could turn for alternative products or sources of the product if a competitor raised prices. . . . The possibilities for substitution must be considered." (citations omitted)). Identifying substitute suppliers is important because, even if a group of consumers has a strong preference for a particular supplier, consumers

could offset an exercise of market power by resorting to substitute suppliers located within the geographic scope of the market. *Miller v. Indiana Hosp.*, 814 F.Supp. at 1262 ("'Because we are concerned only with an area in which competition could be harmed, the relevant geographic market must be broad enough that buyers would be unable to switch to alternative sellers in sufficient numbers to defeat an exercise of market power by firms in the area. . . .'" (quoting *In the Matter of Hosp. Corp. of America,* 106 F.T.C. 361, 466 (1985) *aff'd by Hospital Corp. of America v. FTC,* 807 F.2d 1381 (7th Cir.1986))). Because Dr. Gaynor's proposed geographic market failed to include those facilities which realistically compete with the Hospital, the court finds that Dr. Gaynor's analysis does not accurately portray the geographic market for outpatient cataract surgery services. *See infra* at pp. 61-66.

Even if the court were to accept the Elzinga-Hogerty test with all of its inherent deficiencies, Dr. Gaynor's application of that test suffered from a more fundamental flaw, incomplete data. While the PHC-4 began compiling data regarding outpatient cataract surgery in 1996, the 1996 data did not include any patient origin data for outpatient cataract surgery procedures performed at free-standing surgery centers. As a result, the PHC-4 data for 1996 did not include any cataract surgeries performed at either the Pennsylvania Eye Surgery Center or the Ophthalmology Laser & Surgical Center. Both of these surgical centers are located within thirty miles of the eastern border of Juniata County and both were performing outpatient cataract surgery in 1996. If as few as sixty-one additional patients residing in Dr. Gaynor's twenty-three zip code proposed market received treatment at either of these facilities (or any other free-standing facility in

Pennsylvania for that matter), the data would not satisfy even the weak Elzinga-Hogerty test.[33] (*See* Appendix Ex. B.)

Plaintiffs argue that the geography of central Pennsylvania and the demographics of the typical cataract patient support Dr. Gaynor's Elzinga-Hogerty analysis, indicating an isolated geographic market. However, it is clear that Plaintiffs' arguments regarding the geographic and demographic conditions are inaccurate. To begin with, Plaintiffs contend that elderly cataract patients are unwilling to travel outside Juniata and Mifflin Counties for outpatient surgery. Plaintiffs, however, grossly overexaggerate the hardships of traveling from Mifflin and Juniata counties to hospitals lying in close proximity to these areas. Three facilities that perform outpatient cataract surgery are located within a thirty-six mile drive from Lewistown Hospital, which is located at, or near, the geographic epicenter of Plaintiffs' proposed geographic market. These facilities are J.C. Blair Hospital in Huntingdon County, Pennsylvania (approximately thirty-six driving miles away); Centre Community Hospital in State College, Pennsylvania (approximately thirty-one driving miles away); and Centre Community Surgical Center (located adjacent to Centre Community Hospital). According to mapquest.com, it would take a person traveling from Lewistown Hospital fifty-six minutes to travel to J.C. Blair Hospital and thirty-nine minutes to travel to Centre Community Surgical Center or Centre Community Hospital. (*See* Attached Exs. C and D.)[34] Of course,

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[33] 670 patients from Dr. Gaynor's proposed twenty-three zip code market underwent outpatient cataract surgery at hospitals in 1996.

[34] The court may take judicial notice of these facts. *See* Fed.R.Evid. 201.

many residents of Mifflin and Juniata Counties live in areas which are a much shorter drive to these facilities. For those patients, J.C. Blair, Centre Community Hospital, and Centre Community Surgical Center are obviously attractive options for patients seeking to have outpatient cataract surgery. These facilities are each located within five miles of highways – U.S. Routes 22, 322, and 522 – which also traverse both Mifflin and Juniata Counties.

The statistics back up this conclusion. In 1996, 635 "Gordon/Nancollas" procedures were performed at the Hospital.[35] 589, or 92.8%, of these procedures were performed on patients coming from a twenty-eight zip code area. From this same area, the Centre Community facilities drew 243 patients and J.C. Blair drew 188 patients. The Hospital's share of all "Gordon/Nancollas" procedure patients in these zip codes was 46.3%. Meanwhile, the Centre Community facilities and J.C. Blair had 19.1% and 14.8% shares respectively. The remaining 19.5% of patients sought treatment from facilities located over thirty miles from Lewistown. While the Hospital may have been the dominant player in this market, the numbers indicate that ophthalmic surgery patients viewed Centre Community and J.C. Blair as viable substitutes to whom they could resort in the event the Hospital attempted to decrease output or lower quality.

Likewise, Plaintiffs' claim regarding the demographics of cataract patients and the topography of central Pennsylvania is also flawed. Plaintiffs claim that because

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[35] As stated previously, outpatient cataract surgery procedures accounted for over 95% of the Gordon/Nancollas procedures. (*See* Tr. (Harris) at 2346.)

cataract patients are elderly and often cannot drive long distances, or are prohibited by law from driving at all, they are unwilling or unable to undergo outpatient cataract surgery anywhere outside of Mifflin and/or Juniata County. This contention, however, neglects the fact that cataract removal surgery is an outpatient procedure which renders the patient unable to drive afterwards. As a result, patients undergoing this procedure must have someone with them who will drive them home after they are discharged. Therefore, unless these elderly patients walk to the Hospital for outpatient cataract surgery, their ability or willingness to drive outside of Plaintiffs' proposed geographic market is not a reliable indicator of whether J.C. Blair, the Centre Community facilities, or any other facilities are realistic options for patients in this area.

Even if the court were to impute the patients' unwillingness or inability to drive longer distances to their drivers, the court finds that, due to the seriousness of cataracts, the distances between Juniata and Mifflin Counties and these facilities are not so great that patients would not view these facilities as realistic alternatives to the Hospital and its surgeons. A cataract fundamentally affects a person's ability to see, oftentimes limiting the patient's ability to perform their job or to live their life in the manner to which the patient is accustomed. As a result, patients should be willing to travel at least some appreciable distance for treatment. While convenience of location is somewhat important to consumers, the court cannot say that patients would not be willing to travel up to an hour for treatment. J.C. Blair and the Centre Community facilities are only a twenty minute to an hour drive away from patients residing in Mifflin and Juniata

Counties, and thus must be considered as competitors with the Hospital for outpatient cataract surgery patients.

It should be noted that in 1996, these facilities most likely viewed the Hospital and its surgeons as competitors. During that year, seventeen patients from zip code 16652 had a Gordon/Nancollas procedure performed on them at the Hospital. J.C. Blair is located in zip code 16652. If seventeen patients from that zip code – or 14.2% of all patients in that zip code who were treated for cataracts in 1996 – were willing to travel to Lewistown for treatment despite the fact that J.C. Blair was located practically next door, this would seem to cut against Plaintiffs' contention that elderly patients are unwilling to cross the mountain ranges for treatment. Presumably, patients traveling from Huntingdon would encounter the same obstacles traveling to Lewistown as patients from Mifflin and Juniata Counties would face in traveling to J.C. Blair.

Similarly, the Hospital performed Gordon/Nancollas procedures on eleven patients from zip code 16823. This represented a 5.4% share of all patients from that zip code, which corresponds to the village of Bellefonte, located no more than fifteen driving miles north of State College, but at least thirty driving miles from Lewistown. (*See* Appendix, Exs. E and F.) To travel from Bellefonte to Lewistown, patients use the same highway, Route 322, that patients use to travel from Mifflin and Juniata Counties to the Centre Community facilities in State College.

If twenty-eight patients from these two rural zip codes located in close proximity to other facilities were willing to cross the mountain ranges and travel over twice the distance to have their outpatient cataract surgery performed at the Hospital, then this undercuts Plaintiffs'

contention that the Hospital was not in competition with J.C. Blair and the Centre Community facilities. If the Hospital was viewed as a viable alternative for patients living directly outside of Mifflin and Juniata Counties, then surely facilities lying directly outside Mifflin and Juniata Counties were viewed as viable alternative facilities by patients residing within Mifflin and Juniata Counties. As a result, these facilities must be included in any calculation regarding the Hospital's market share.

At the very least, referring optometrists in Lewistown viewed many other facilities outside Mifflin and Juniata Counties as viable alternatives for their patients.[36] Because most patients see their optometrists on a regular basis, optometrists are generally the physicians who first diagnose a patient as suffering from cataracts. Consequently, referrals from optometrists are an important source of patients for ophthalmologists who perform outpatient cataract surgery. Their referrals are reliable indicators of realistic alternative facilities which should be included in any properly defined geographic market. At trial, two optometrists practicing in Lewistown, Dr. Robert Burns and Dr. Michael Hutton, testified regarding their pattern of referrals. Dr. Burns testified that he informs patients whom he has diagnosed with cataracts that they can obtain treatment from physicians in Lewistown, State College, Lewisburg, Harrisburg, and even Altoona. Likewise, Dr. Hutton has referred cataract patients to

[36] Basically, optometry involves examining the human eye for pathologies and the treatment of minor eye diseases such as conjunctivitis – inflamation of the eye. While optometrists may write prescriptions for eye glasses and some medications, they are not able to perform surgery. (*See* Tr. (Burns) at 2122.)

physicians practicing in Lewistown, Lewisburg, State College, Harrisburg, and Huntingdon. This testimony, by physicians who are reliable barometers of competitive conditions in the physician services markets, further bolsters the conclusion that physicians and patients can, and do, choose from a variety of facilities and physicians both in and outside of Plaintiffs' proposed geographic area in deciding where to have outpatient cataract surgery performed. Thus, patients in Mifflin and Juniata Counties are not, as Plaintiffs contend, limited to choosing Lewistown Hospital and its physicians for cataract surgery. *See Cogan v. Harford Mem'l Hosp.*, 843 F.Supp. 1013, 1019 (D.Md.1994) ("The relevant geographic market must include those facilities which referring physicians and patients would perceive as attractive alternatives to [the defendant].").

Plaintiffs also contend that several pieces of disparate evidence indicate both that the Hospital viewed Mifflin and Juniata Counties as the geographic market for outpatient cataract facility services, and other industry participants echoed this view. Specifically, Plaintiffs rely upon a statement that the Hospital's Administration made to Standard & Poor's, a bond credit rating company, to the effect that the Hospital has a "dominant market position as a sole community provider that captures 77% of all discharges *in the primary service area of Mifflin and Juniata Counties.*" (Pl.Ex. 110 (emphasis added).) Plaintiffs also point to a statement, by Hospital personnel, in opposition to Dr. Gordon's application for a CON to open his proposed surgical center. In that document, the Hospital defined their primary service area as Mifflin and

Juniata Counties. (*See* Def. Ex. 39.)[37] Plaintiffs highlight a similar statement in a presentation put together by a consultant on behalf of the Hospital. (*See* Def. Ex. 25.)

These statements, however, refer to the Hospital's primary service area, not the geographic market for outpatient cataract surgery services. There is voluminous case law holding that a firm's service area, alone, does not equate to a market's geographic scope. *See, e.g., Surgical Care Ctr. v. Hospital Serv. Dist. No. 1,* 309 F.3d 836, 840 (5th Cir.2002) ("'[T]rade area is not necessarily the relevant geographic market for purposes of antitrust analysis' because geographic market evidence must take into account 'where consumers could practicably go, not where they actually go.'" (quoting *Minnesota Ass'n of Nurse Anesthetists v. Unity Hosp.,* 208 F.3d 655, 662 (8th Cir.2000))); *Tenet Health Care,* 186 F.3d at 1052 ("A service area, however, is not necessarily a merging firm's geographic market for purposes of antitrust analysis."); *Bathke v. Casey's General Stores, Inc.,* 64 F.3d 340, 346-47 (8th Cir.1995) (rejecting service area as proposed geographic market because such a conclusion "looks at the issue only from the perspective of Casey's rivals, not from the perspective of the consumer"); *Tunis Bros. v. Ford Motor Co.,* 952 F.2d 715, 726 (3d Cir.1991) ("[T]he geographic market is not comprised of the region in which the seller attempts to sell its product, but rather is comprised of the area where his customers would look to buy such a product."); *Delaware Health Care, Inc. v. MCD Holding Co.,* 957 F.Supp. 535, 540 (D.Del.1997) (quoting *Tunis Bros.,* 952 F.2d at 726); *Miller v. Indiana Hosp.,* 814

[37] This document, however, also includes Snyder and Huntingdon Counties in its definition of its primary service area. (*See id.* at p. 15.)

F.Supp. at 1263 ("[A] county is not the relevant geographic market in a single hospital county merely based on the hospital's service area."); *Doctors Steuer & Latham, P.A. v. National Med. Enters., Inc.*, 672 F.Supp. 1489, 1511 (D.S.C.1987) ("In order to convert a 'service area' into a geographic market, it is necessary to offer evidence regarding elasticity of demand and barriers to entry. . . . ").

Other relevant evidence tends to rebut Plaintiffs' contention that the Hospital's service area and the geographic scope of the outpatient cataract surgery markets are coextensive. There are several other large facilities and high quality physicians located in close proximity to Plaintiffs' proposed market who could provide substitute service in the event the Hospital attempted to lower product quality or production levels. Additionally, while the obstacles to entry in the outpatient cataract facility services market are more than minimal, the court cannot conclude that these obstacles effectively preclude the entry of alternative producers. Dr. Gordon's opening of MCCSC undercuts such a conclusion.[38] This is not to say that evidence of a firm's service area is irrelevant to defining the geographic market. However, where, as here, the other evidence strongly repudiates a finding that the service area and the geographic market are co-extensive, the court will not accept the service area as the relevant geographic market for calculating the defendant's market share. *See Fineman v. Armstrong World Indus., Inc.*, 980 F.2d 171,

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[38] With respect to the physician services aspect of the outpatient cataract surgery market, a physician need only obtain privileges at the Hospital, or another nearby hospital or surgery center (J.C. Blair, Centre Community, or even MCCSC for example), to begin immediately competing with Dr. Nancollas.

202 (3d Cir.1992) (quoting *Weiss v. York Hosp.*, 745 F.2d 786, 827 n. 72 (internal citations omitted)).

In sum, the court finds that Plaintiffs failed to satisfy their burden of proving the relevant geographic markets for outpatient cataract surgery facility and physician services. The relevant geographic market is not limited to Mifflin and Juniata Counties. Instead, the geographic market also includes those portions of the following counties which are located within a thirty mile radius of Lewistown: Snyder, Union, Clinton, Centre, Huntingdon, Franklin, Cumberland, and Perry. Plaintiffs have not included any calculation of the Hospital's share of outpatient cataract surgery patients in this expanded market.

Additionally, the court holds that Plaintiffs have failed to prove that the Hospital had market power in the relevant geographic market for outpatient cataract facility services. In the twenty-eight zip codes from which the Hospital drew 92.8% of their patients undergoing outpatient ophthalmic surgery in 1996, the Hospital's overall share was only 39%. The Third Circuit has held that a 55% market share is insufficient, as a matter of law, to establish that a firm possesses market power. *See Fineman*, 980 F.2d at 201; *see also Domed Stadium Hotel, Inc. v. Holiday Inns, Inc.*, 732 F.2d 480, 489 (5th Cir.1984) (holding that even 60% market share is unlikely to suffice). *But see American Tobacco Co. v. United States*, 328 U.S. 781, 797, 66 S.Ct. 1125, 90 L.Ed. 1575 (1946) (holding that a two-thirds share, or approximately 66%, is sufficient to establish the inference of market power). As a result, the Hospital's 39% market share is legally deficient to establish market power.

For the following reasons, however, this number is not entirely indicative of the Hospital's market share for outpatient cataract surgery services in 1996: (1) this area contains five zip codes – 17243, 17264, 16611, 16853, and 17842 – which fall either fully or partially outside the thirty mile radius; and (2) the numbers compiled reflect all outpatient ophthalmic surgery cases – both cataract and non-cataract procedures. Nevertheless, the testimony at trial indicated that cataract surgeries constituted over 95% of all "Gordon/Nancollas" cases. Thus, if one were to remove the cases of those patients residing in the five zip codes which fall either fully or partially outside of the thirty mile radius and assume that all non-cataract outpatient procedures were performed at facilities other than the Hospital, the Hospital's market share would still only be 45.8%. It should also be remembered that this data does not include any procedures performed at free-standing surgery centers. *See supra* at pp. 59-60. Moreover, even if the court excludes all other facilities except the Hospital, J.C. Blair, and the Centre Community facilities – the only facilities performing outpatient cataract surgery in 1996 and located in the thirty mile radius – and it excludes those zip codes falling partially or fully outside the thirty mile radius, *and* the court assumes that all non-cataract procedures were performed at J.C. Blair and the Centre Community facilities, the Hospital's market share is still only 63.5%. While this is closer to the 66% threshold, it does not meet the threshold test and is based on a series of conservative assumptions which do not correspond to reality.

Similarly, the "Gordon/Nancollas" numbers for 1999 demonstrate a dramatic fall in the Hospital's market share. In that year, the Hospital drew 93% of its patients

from a fifteen zip code area falling entirely within both Plaintiffs' proposed market and the court's thirty-mile radius market. Yet, the Hospital's share of this fifteen zip code area was only 32.3%. Even if one excludes all facilities located outside this fifteen zip code area, which excludes both Centre Community and J.C. Blair, and one assumes that all non-cataract procedures were performed at facilities other than the Hospital, the Hospital's market share is still only approximately 42.3%. The Hospital wasn't even the dominant provider of outpatient cataract surgery services in this area in 1999. Dr. Gordon performed 189 Gordon/Nancollas procedures on patients from this [sic] areas at MCCSC that year. Dr. Nancollas, the lone ophthalmologist at the Hospital in 1999, performed only 160 such procedures on patients from this area. That Dr. Gordon was able to open an alternative facility – which became the dominant provider of outpatient cataract surgery services within less than two years of the Hospital's decision to revoke Dr. Gordon's privileges – tends to undercut the argument that the Hospital possessed market power in the facility services market sufficiently strong to alter competition in both the physician services and facility services markets for outpatient cataract surgery.

While these conclusions are not based on exact calculations of the Hospital's market share, they do demonstrate how woefully short the Hospital was of obtaining the benchmark 66% market share necessary for the court to infer market power. They are the court's best estimation of the Hospital's market share. Neither party provided the PHC-4 data to the court. In conclusion, the court finds that Plaintiffs have not demonstrated that the Hospital possessed

market power in the market for outpatient cataract facility services.

-Inpatient Eye Surgery Facility Services

Plaintiffs contend that, like their proposed market for outpatient cataract surgery facility services, the geographic markets for the inpatient eye surgery facility services market consists of Mifflin and Juniata Counties. In support of this contention, Dr. Gaynor performed an Elzinga-Hogerty test using patient migration data for all inpatient procedures. Dr. Gaynor's calculations established a twenty-two zip code market for inpatient procedures which satisfied the weak market Elzinga-Hogerty standard, but not the strong market. This area encompasses almost all of Mifflin and Juniata Counties. For this reason, Dr. Gaynor opined that the geographic markets for inpatient eye surgery facility and physician services consist of Mifflin and Juniata Counties.

Unlike his analysis of outpatient cataract surgery patient migration data, the inpatient analysis did not suffer from incomplete data with respect to free-standing surgery centers because all inpatient procedures must be performed in a hospital. Moreover, the analysis of inpatient procedures was not as sensitive to the ordering of zip codes. The court rearranged the zip code analysis, sorting out zip codes in order of their importance to the Hospital. The court found that a seventeen zip code area satisfied the weak Elzinga-Hogerty test for general inpatient services. (*See* Appendix, Ex. G.) These seventeen zip codes represented approximately 92% of all inpatient procedures performed at the Hospital in 1996, and 75.4% of the patients undergoing treatment in this area had their

procedure performed at the Hospital. A 75.4% share of the market is enough for the court to conclude that, in 1996, the Hospital had market power in the general inpatient facility services market. *See Fineman*, 980 F.2d at 201-02.

The general inpatient facility services market, however, is not at issue in this case. Rather, Plaintiffs bore the burden of demonstrating the geographic market for inpatient eye surgery facility services. Dr. Gaynor concluded that inpatient eye surgery procedures are so few that he could not perform a reliable statistical study of the geographic market. The court can accept this. However, Dr. Gaynor's conclusion regarding the geographic market for inpatient eye surgery is based on the presumption that this market is accurately portrayed by the geographic market for all inpatient procedures. (*See* Tr. (Gaynor) at 1337-38 (" . . . So my presumption is that the boundaries of the inpatient eye surgery [market] are not substantially different from the boundaries of the market for all inpatient hospital services is a reasonable representation of what the geographic market is for inpatient eye surgery.").) Plaintiffs, however, provide no explanation whatsoever as to why the data regarding general inpatient procedures is a legitimate proxy for data regarding inpatient eye surgery. Without explanation as to why this is so, the court will not accept such a conclusion. Accordingly, the court finds that Plaintiffs' evidence is insufficient to establish the relevant geographic market for inpatient eye surgery facilities services.

Moreover, although the patient migration data for this market is statistically insufficient to do an Elzinga-Hogerty analysis, that data, even when limited to those patients in Plaintiffs' proposed geographic market, indicates that patients are willing to travel longer distances

for inpatient eye surgery than for outpatient cataract surgery. In 1996, nineteen patients from Juniata and Mifflin counties underwent inpatient eye surgery. Of those patients, only eight chose to have their surgery performed at the Hospital. Besides one patient who underwent surgery at J.C. Blair, the remaining patients chose to have their procedures performed at hospitals located between thirty to seventy miles away from Lewistown. In 1998, only eleven patients from Mifflin County underwent inpatient eye surgery. No patients from Juniata County underwent inpatient eye surgery that year. Yet, despite the fact that the Hospital was located in their home county and inside the supposedly travel-restricting mountain ranges, the majority of patients opted to go elsewhere. Of those patients who opted to go elsewhere, 83.3% sought treatment at facilities located at least an hour's drive from Mifflin County.

These numbers seem to indicate that patients are more willing to travel to have inpatient eye surgery, which would comply with common sense. Inpatient surgery, by its very definition, is a more serious procedure and presumably involves treatment for more serious eye ailments than those which can be treated through outpatient care, including cataract removal surgery. Because these conditions are more serious, patients are more willing to travel longer distances for treatment than they would be to undergo an outpatient cataract removal procedure. Accordingly, the geographic market for inpatient eye surgery must be broader than that of outpatient cataract surgery services. Given that the geographic market for outpatient cataract surgery facility services is a thirty-mile radius from Lewistown, the court finds that the geographic market for inpatient eye surgery should include all hospitals within a

fifty-mile radius of Lewistown. Thus, the following hospitals should be included in any calculation of the Hospital's market share in the market for inpatient eye surgery facility services: Lewistown, Centre Community, J.C. Blair, Philipsburg, Tyrone, Altoona, Bon Secours-Holy Family System, Nason, Carlisle, Holy Spirit, Pinnacle Health System (Harrisburg Hospital), Community General Osteopathic, Sunbury Community, and Evangelical Community.

Plaintiffs have not presented the court with a calculation of the Hospital's market share in this area. Thus, the court finds that Plaintiffs have failed to meet their burden of demonstrating that the Hospital possessed market power in the market for inpatient eye surgery facility services. Therefore, the Hospital did not have sufficient power to harm competition in either the facility services or physician services components of the market for inpatient eye surgery.

-Emergency Eye Surgery Facility Services

Plaintiffs claim that the geographic region for emergency eye surgery facilities should be much smaller than it is for outpatient cataract surgery facility services. The court agrees. As testimony at trial, both expert and anecdotal, made gruesomely clear, emergency eye conditions are usually severe and need immediate attention. (*See* Tr. (Hawk) at 644-45;[39] *see also* Tr. (Gaynor) at 1338.) Many of

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[39] At trial, Ms. Hawk described the injury her husband sustained:

Q: What happened right after, if anything, that [metal] strap broke and hit him in the face?

(Continued on following page)

these conditions threaten the patient's permanent vision and can sometimes even result in death. (*See, e.g.* Tr. (Silverstone) at 1071-75.) Thus, logic dictates that patients in an emergency situation will choose to use the emergency facility which is located closest to the patient at the time he or she suffers injury.

After reviewing the evidence regarding the topography of central Pennsylvania and the layout of highway routes, the court concludes that the Hospital is the most conveniently located emergency eye surgery facility in Mifflin and Juniata Counties. For patients living in this area, there are no other reasonable alternative facilities at which they could seek services without traveling a significant distance. In an emergency situation, where limiting the elapse of time between injury and treatment is of utmost importance, patients are unlikely to travel long distances for care. Additionally, it would be extremely difficult for another competitor to enter the market if the Hospital acted to reduce output or lower quality, as Plaintiffs allege it has. To enter this market, a competitor would have to construct a new hospital. Given the rural nature of

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A: He started yelling I lost my, I lost my eye. It hit him right in the eye. That is what he figured happened. Whenever he got hit in the eye, he figured something happened to his eye.

So I jumped out of the truck. I walked over. I looked at it. There was like a lot of white – all like a lot of gooey stuff in the front hanging down on his cheek.

Q: Could you see what people ordinarily think to be an eye?

A: The eye wasn't hanging out. It was like – I found it was like from the back of the eye hanging.

(Tr. (Hawk) at 644-45.)

this area, it is doubtful that the costs of such an endeavor would be fiscally viable. Based on these factors, the court finds that Plaintiffs have established that the relevant geographic market for emergency eye surgery facility services is Mifflin and Juniata Counties. Consequently, because the Hospital is the only facility at which patients can obtain such care in this geographic area, the court finds that the Hospital has a 100% share of this market. This, of course, is sufficient to demonstrate that the Hospital has market power in the market for emergency eye surgery facility services.

iii. Market Analysis Conclusion

In conclusion, the court finds that the following constitute [sic] the relevant product markets in this case: (1) outpatient cataract facility services; (2) outpatient cataract physician services; (3) facility services for inpatient eye surgery; (4) facility services for emergency eye surgery; (5) physician services for inpatient eye surgery; and (6) physician services for emergency eye surgery. These are essentially three sets of complementary product markets. Because the product markets are complementary, their geographic market should be identical.

The court finds that Plaintiffs failed to meet their burden of demonstrating that the outpatient cataract surgery services markets consist only of Mifflin and Juniata Counties. Instead, the court finds that the geographic market for outpatient cataract surgery facility services includes all hospitals and surgical centers located within thirty miles of Lewistown. Additionally, Plaintiffs have likewise failed to establish that Mifflin and Juniata Counties constitute the geographic market for inpatient

eye surgery facility services. Instead, the court finds that the geographic market for inpatient eye surgery facility services must include all hospitals located within a fifty-mile radius of Lewistown. Likewise, the court finds that Plaintiffs have failed to demonstrate that the Hospital has, or at one time possessed, market power in the relevant geographic markets for either outpatient cataract surgery facility services or inpatient eye surgery facility services. Because the Hospital does not provide physician services, it cannot have market power in any of the complimentary physician services markets at issue in this case.

The court, however, finds that Plaintiffs have met their burden of demonstrating that Mifflin and Juniata Counties are the geographic border of the emergency eye surgery facility services market. Similarly, the court finds that Plaintiffs have demonstrated that the Hospital has market power in the relevant geographic area of the emergency eye surgery facility services product market.

c. Actual Anti-Competitive Effects

Although the court has found that Plaintiffs failed to meet their burden of demonstrating that the Hospital possessed market power in the facility services markets for outpatient cataract surgery and inpatient eye surgery, Plaintiffs may still satisfy their initial burden by demonstrating that the Hospital's actions had an actual adverse effect on competition in these markets or in the complimentary physician services markets. *See United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir.1993). Injury to Dr. Gordon's practice is not dispositive of this issue. "In other words because 'antitrust law aims to protect competition,

not competitors [a court] must analyze the antitrust injury question from the viewpoint of the consumer.'" *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 641 (3d Cir.1996) (quoting *Alberta Gas Chemicals, Ltd. v. E.I. Du Pont De Nemours and Co.*, 826 F.2d 1235, 1240 (3d Cir.1987) (internal citations omitted)); *see also Miller v. Indiana Hosp.*, 814 F.Supp. at 1265 ("'For example, the fact that a hospital's decision caused a disappointed physician to practice medicine elsewhere does not of itself constitute an antitrust injury. If the law were otherwise, many a physician's workplace grievance with a hospital would be elevated to the status of an antitrust action.'" (quoting *Oksanen v. Page Mem'l Hosp.*, 945 F.2d 696, 708 (4th Cir.1991) (internal citation omitted))). "An antitrust plaintiff must prove that challenged conduct affected the prices, quantity or quality of goods or services, . . . " not just his own welfare. *Tunis Bros. Co., Inc. v. Ford Motor Co.*, 952 F.2d 715, 728 (3d Cir.1991). Even if the plaintiff is successful in proving that output dropped or quality suffered, the plaintiff must still demonstrate that the defendant's conduct proximately caused the detrimental effect on competition. *Petruzzi's IGA Supermkts., Inc. v. Darling-Delaware Co.*, 998 F.2d 1224, 1229 (3d Cir.1993).

In this case, Plaintiffs contend that the Conditions of Reappointment adversely affected competition in two ways. First, Plaintiffs claim that the Conditions limited Dr. Gordon's ability to communicate truthful comparative information to patients and other members of the Medical-Dental Staff. Second, Plaintiffs claim that the Hospital's exclusion of Dr. Gordon – which flowed from the Hospital's decision to impose the Conditions of Reappointment – injured competition by ensuring that there was insufficient providers of physician services to cover demand and

by limiting patients' access to superior ophthalmic surgical services.[40]

As to Plaintiffs' first argument, the court agrees with Plaintiffs that the communication of truthful information to patients and other physicians is an important aspect of competition in the field of medicine. As stated earlier, physicians compete with each other primarily based on the quality of their service. *See supra* at Part II.A.1.b.i. Therefore, it follows that any unreasonable restraint on the free flow of information regarding the quality of service or surgical method, to either patients or referring physicians, will have an adverse effect on competition among physicians. However, reasonable regulations of the time, place, and manner of such communication encourage, rather than impede, robust competition by ensuring that its content is truthful, complete, and ethical. If the court were to adopt Plaintiffs' argument, any restraint on a physician's ability to communicate truthful medical information would constitute an adverse effect on competition. Thus, hypothetically, the Hospital's decision to discipline Dr. Gordon if he choose [sic] to drive around Lewistown in the

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[40] To the extent Plaintiffs also argue that the Hospital injured competition in the facility services markets through its exclusive contract with the anesthesiologists, that claim must fail. The market for such services is national in scope. *See Balaklaw v. Lovell*, 14 F.3d 793, 799 (2d Cir.1994) (affirming dismissal of Section 1 claim against hospital for exclusive dealing arising out of exclusive contract with anesthesiologists, in part, because "anesthesiologists compete in a multi-state, if not national, market"). Therefore, the Hospital's exclusive contract with its anesthesiologists did not injure competition in the facility services markets at issue in this case. Any facility needing an anesthesiologist to function could recruit such a physician from any source other than the Hospital; as Dr. Gordon did when he opened MCCSC.

wee hours of the morning proclaiming the benefits of phacoemulsification from a bull horn would be subject to antitrust scrutiny. Obviously, preventing a physician from engaging in such conduct does not harm competition. Therefore, a reasonable restraint on the dissemination of truthful information – that is, one which regulates the context in which the information is conveyed, rather than the content of that information – does not harm competition. *See, e.g., Oksanen,* 945 F.2d at 708 (4th Cir.1991) ("To keep the antitrust laws from becoming trivialized, the reasonableness of a restraint is evaluated based on its impact on competition as a whole within the relevant market.") (citing *Atlantic Richfield Co. v. USA Petroleum Co.,* 495 U.S. 328, 110 S.Ct. 1884, 109 L.Ed.2d 333 (1990)).

In this sense, the court finds that the Conditions of Reappointment did not limit Dr. Gordon's ability to communicate truthful comparative information through advertising or any other means. Instead, Condition 2 merely regulated the manner in which Dr. Gordon could register internal complaints about any member of the Hospital staff, including Dr. Nancollas. Dr. Gordon was prone to engage in tempestuous verbal attacks on Dr. Nancollas and the nursing staff, sometimes in the presence of patients. Thus, the Credentials Committee felt it necessary to clearly delineate to him the proper means of registering such complaints. The Hospital did not prevent Dr. Gordon from making complaints or highlighting what he perceived as Dr. Nancollas' medically unsafe practices. To the contrary, on the single occasion that Dr. Gordon choose [sic] to express his concerns by registering a written complaint – the June 4, 1997 letter – the Hospital responded by launching a quality study even though Dr.

Gordon inappropriately disseminated the letter to over thirty people.

Similarly, Condition 3 regulated the manner in which Dr. Gordon could communicate with patients of other physicians. Dr. Gordon had a practice of contacting Dr. Nancollas' patients for the purpose of verbally disparaging him. Sometimes, this occurred the night before Dr. Nancollas was to perform surgery on these patients. As a result, the Hospital felt it necessary to impose some limitations on how Dr. Gordon communicated with patients. Given Dr. Gordon's history, the court cannot say that this was unreasonable. Channeling complaints through the proper avenues assures that any organization, especially one as important as a hospital, is run in an efficient and effective manner.

Moreover, so long as Dr. Gordon did not mention Dr. Nancollas' name and Dr. Gordon did not intentionally contact Dr. Nancollas' patients, nothing in either Condition prevented Dr. Gordon from advertising or from highlighting the benefits of his method of cataract removal surgery over the ECCE method and the anesthesia complications of Dr. Nancollas' method to potential patients. Dr. Gordon placed at least two ads in the Lewistown Sentinel – on May 1, 1997 and on September 16, 1997 – after the Hospital imposed the Conditions of Reappointment. In the second ad, Dr. Gordon pointed out the increased risks of Dr. Nancollas' procedure without referring to him by name or as "the Geisinger physician." The Hospital took no disciplinary action against Dr. Gordon as a result of these ads. In fact, on the lone occasion that the Hospital even intimated that Dr. Gordon might be subject to discipline based on the content of his advertisements, it did so only because it believed that Dr. Gordon had included

dishonest or materially misleading information about an alleged survey of anesthesiologists practicing at the Hospital. *See supra* at Part I.D.5. However, even on that occasion Whitcomb stated that, "[i]t is recognized that you have the right to place such advertisements and to control the content thereof." (Pls.Ex. 173.)

Therefore, the court finds that the Conditions of Reappointment did not, as Plaintiffs contend, unreasonably limit Dr. Gordon's ability to communicate truthful information to patients and other physicians. Instead, these conditions merely regulated the manner and context in which Dr. Gordon would be allowed to communicate this information. Such regulations, so long as they are reasonable in light of the surrounding circumstances, do not constitute adverse effects on competition. In this case, given Dr. Gordon's tendency to engage in vituperative discourse about Dr. Nancollas in inappropriate settings, the court finds that Conditions 2 and 3 were reasonable. *See infra* at Part II.A.2.

Dr. Gordon also contends that the Conditions of Reappointment resulted in his being excluded from the Hospital and that this limited the natural range of options in the marketplace in at least two ways. First, according to Dr. Gordon, the restraint left consumers with insufficient emergency eye surgery physician services and outpatient cataract surgery physician services. Second, the exclusion denied patients the choice of a higher quality ophthalmologist.

With respect to insufficient service, even assuming that Dr. Gordon's exclusion flowed from the Conditions of Reappointment, the evidence did not demonstrate that his exclusion prevented Dr. Gordon from treating cataract

patients. Instead, the exclusion only prevented Dr. Gordon from treating cataract patients at the Hospital. This may constitute an injury to Dr. Gordon, but it does not constitute an injury to competition among providers of outpatient cataract surgery physician services. *See, e.g., Mathews,* 87 F.3d at 641 ("The district court also pointed out that the Board's restrictions on Dr. Mathews privileges do not completely extinguish Dr. Mathews' ability to provide low cost services, but merely curtail his ability to perform spine surgery at Lancaster General. We believe the record supports [this] conclusion."); *see also Urdinaran v. Aarons,* 115 F.Supp.2d 484, 491 (D.N.J.2000) ("[I]n light of the fact that Plaintiff voluntarily relinquished his privileges . . . there is some question whether he can allege damages at all. . . . [E]ven if he could, [Plaintiff] provided no evidence that his patients could not have still utilized his services at Shore Memorial . . . which is . . . a few miles away. . . ."). Dr. Gordon has opened his own surgery center and is now treating a significant number of cataract patients. Additionally, there are several other physicians performing outpatient cataract surgery in this area. Even during the period between the Hospital's decision to expel Dr. Gordon and the opening of MCCSC, Dr. Gordon performed a substantial number of surgeries on residents of the Mifflin/Juniata Counties area at the Pennsylvania Eye Surgery Center. In short, there were, and continue to be, enough providers of outpatient cataract surgery physician services in this area to meet demand. *See Mathews,* 87 F.3d at 641 ("The district court found the evidence does not support the existence of an antitrust injury resulting from a restriction on Dr. Mathews' privileges . . . because orthopedic services are still readily available to consumers in the Lancaster area from a large and ever-increasing number of providers."); (*see also* Def. Ex. 547, Ex. 18 at p.

2) (indicating that in 1997, 895 patients from the Hospital's service area underwent a Gordon/Nancollas Procedure, while in 1999, 1,479 patients from this area underwent such a procedure).[41]

Only with respect to the emergency eye surgery physician services market does Plaintiffs' contention as to insufficient service have any plausible merit. In this context, there is now only one provider of emergency eye surgery physician services in the relevant geographic market, Dr. Nancollas. Testimony at trial indicated that it is unlikely that one ophthalmologist can provide sufficient emergency room coverage. (*See, e.g.*, Tr. (Silverstone) at 1075 ("Q: . . . Is it your opinion Dr. Silverstone, that Dr. Nancollas is unable to supply on a sole source basis adequate hospital emergency services for ophthalmic problems? A: You could substitute any doctor's name there. One doctor cannot . . . be a sole source of adequate hospital service for ophthalmic problems.").) Moreover, anecdotal evidence at trial supported this conclusion. (*See, e.g.*, Tr. (Hawk) at 646-48 (indicating that after stabilization, Hawk's husband was transferred by ambulance from the Hospital to Geisinger Hospital in Danville – almost two hours away – to undergo emergency eye surgery).)

However, it is one thing to say that Dr. Gordon's exclusion has caused an injury to competition in the

[41] Plaintiffs presented no evidence whatsoever indicating that there are not enough providers of inpatient eye surgery physician services to meet demand. Moreover, the court finds that any such contention would be implausible. Inpatient eye surgery is quite rare and the geographic scope of this market is quite broad. *See supra* at Part II.A.1.b.i. Therefore, it is almost impossible that there are not enough ophthalmologists in the market to meet current levels of demand.

emergency eye surgery physician services market, it is quite another to say that the Hospital's decision to impose the Conditions of Reappointment caused this injury. Plaintiffs seem to be arguing *res ipsa loquitur* ("the thing speaks for itself"). That is, the Hospital imposed the Conditions, Dr. Gordon had his privileges revoked for violating the Conditions, and now there are insufficient ophthalmologists to provide emergency eye surgery services in the geographic market. Therefore, the Hospital's decision to impose the Conditions of Reappointment must have caused the injury to competition. However, as stated above, the Conditions of Reappointment were reasonable in light of Dr. Gordon's past conduct. Additionally, the Conditions at issue did not mention emergency eye surgery services and did not impact, in any way, Dr. Gordon's ability to provide such service.[42] Therefore, Dr. Gordon's conscious decision to violate the Conditions, rather than the decision to impose the Conditions, caused the injury to competition.[43] Had Dr. Gordon not violated the Conditions, he would not have been excluded. If he would not have been excluded, there would be enough ophthalmologists at the Hospital to provide the necessary level of service.

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[42] Moreover, the Third Circuit has held that *res ipsa loquitur* is an impermissible manner of proving causation in cases evaluated under the rule of reason test. *See Town and Sound Custom Tops v. Chrysler Motors Corp.*, 959 F.2d 468, 486 (3d Cir.1992) ("To the extent that *res ipsa loquitur* . . . is a doctrine of the antitrust laws, it is limited to per se cases.").

[43] If, on the other hand, the Conditions were unreasonably broad and precluded reasonable dissemination of truthful information to consumers, then the court could very well conclude that the injury to competition occurred as a result of the Hospital's decision to impose unreasonable restraints. However, as stated below, the Conditions were reasonable and narrowly tailored given Dr. Gordon's prior conduct. *See infra* at Parts I.A.2 and 3.

Thus, it is Dr. Gordon's conduct, rather than the Hospital's decision, that injured competition. This is demonstrated by the fact that in the period between when the Hospital imposed the Conditions and Dr. Gordon was ultimately excluded from the Hospital, no injury to competition in the emergency eye surgery physician services market took place. Dr. Gordon's conduct is an intervening cause, breaking the chain of causation between the Hospital's decision to impose the Conditions and the ultimate injury to competition. As a result, the Hospital's decision was not the proximate cause of that injury. Likewise, with respect to the physician services markets for outpatient cataract eye surgery, even if the court were to accept Plaintiffs' averment that there is, or was at one time, insufficient service to satisfy demand, this does not automatically lead to the conclusion that the Hospital's decision to impose the Conditions proximately caused it.

Plaintiffs' contention that the Hospital's decision to impose the Conditions foreclosed patients from access to higher quality ophthalmic service suffers from the same defect.[44] That is, even if the court were to assume that patients are forced to use lower quality services, it is Dr.

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[44] Moreover, it is clear that even if Dr. Gordon were excluded from the market altogether, there are other physicians in the market providing high-quality care. Even Dr. Nancollas' ECCE and phaco procedures, about which Dr. Gordon cavils at length, fall within the standard of care. Although Dr. Gordon may have been the most surgically talented ophthalmologist in this area, the other ophthalmologists are perfectly capable of providing adequate high-quality care to patients in his place. Therefore, this injury is not sufficient to qualify as an antitrust injury. *See Doctors Steuer & Latham, P.A. v. National Med. Enters.*, 672 F.Supp. 1489, 1504 (D.S.C.1987) ("Practices that produce only an 'insignificant,' 'de minimis,' 'trivial,' or 'insubstantial' restriction on competition are not unlawful.")

Gordon's decision to violate those Conditions which produced the adverse consequence to consumers. As a result, the court finds that Plaintiffs have failed to prove anti-competitive effects which were proximately caused by the Hospital's decision to impose paragraphs 2 and 3 of the Conditions of Reappointment.

d. Summation of Plaintiffs' Initial Burden

Plaintiffs have satisfied their initial burden of demonstrating that the Hospital engaged in concerted action placing its conduct within the purview of Section 1 of the Sherman Act. *See supra* at Part II.A.1.a. However, with the exception of the market for emergency eye surgery facility services, Plaintiffs have failed to meet their initial burden under the rule of reason. First, Plaintiffs have failed to demonstrate that the Hospital possessed market power in the facility services markets for outpatient cataract surgery and inpatient eye surgery. *See id.* at Part II.A.1.b. Second, the Hospital is not a participant in the physician services component of any of these markets, and, therefore, cannot possess market power in those markets. Third, to the extent any injury to competition occurred in the [sic] either the facility or physician services markets, the Hospital's decision to impose the Conditions of Reappointment was not the proximate cause of those antitrust injuries. *See id.* at Part II.A.1.c.

2. The Hospital's Pro-Competitive Objective

Once a plaintiff has successfully met its initial burden under the traditional rule of reason, the burden then shifts to the defendant to "show that the challenged conduct promotes a sufficiently pro-competitive objective." *United*

States v. Brown Univ., 5 F.3d 658, 669 (3d Cir.1993). The Hospital contends that its decision to impose the Conditions of Reappointment on Dr. Gordon was necessary to protect the internal cohesiveness of the Hospital's Staff. Additionally, by regulating the conduct of a persistently disruptive physician, the Hospital contends it intended to ensure that it would continue to provide high quality medical service to its patients, thus protecting and furthering its ability to compete with other facilities. Even assuming that Plaintiffs had satisfied their initial burden with respect to each of the antitrust markets in this case, the court would find that the Hospital met its burden of demonstrating that the Conditions of Reappointment served a pro-competitive objective. As the Third Circuit has stated:

> [W]e do not doubt that a hospital could exclude an applicant from staff privileges either because he is not medically qualified or because of unprofessional conduct, so long as the hospital applies the same standards to all applicants. This result does not skew our antitrust analysis. First, as to medical ability, restricting staff privileges to doctors who have achieved a specified level of medical ability falls within the scope of a hospital's "public service" function. . . . Applying the rule of reason analysis, it seems obvious that by restricting staff privileges to doctors who have achieved a predetermined level of medical competence, a hospital will enhance its reputation and the quality of the medical care that it delivers. Thus such action is pro-competitive and, therefore, permissible under the rule of reason. . . . The analysis for professional conduct is basically identical. The "public service" function of a hospital is to provide for effective and efficient medical treatment for its

> patients. One factor in the effective and efficient running of a hospital is a medical staff that can work together and be courteous to patients and staff. Doctors who have a history of trouble in interpersonal relations can legitimately be excluded because, if admitted, they will reduce the effectiveness of the medical staff, thereby reducing the ability of the hospital to provide top-flight service. In sum, doctors who have trouble getting along with other people will reduce efficiency, thereby reducing the hospital's competitive position, and, therefore, exclusion of such doctors is pro-competitive and permissible under the rule of reason.

Weiss v. York Hosp., 745 F.2d 786, 821 n. 60 (3d Cir.1984) (citing Andrew K. Dolan & Richard S. Ralston, *Hospital Admitting Privileges and the Sherman Act,* 18 Houston L.Rev. 707, 719 and 735 (1981)).

If denying staff privileges to a physician based on unprofessional conduct is a sufficient pro-competitive justification under the rule of reason, then placing reasonable conditions on a chronically disruptive physician's reappointment likewise serves the same pro-competitive ends. Because Dr. Gordon violated the Conditions of Reappointment, the Hospital's decision to expel him similarly serves interests that are consistent with the Sherman Act. Although it is unclear whether any other physician at the Hospital was subject to a conditional reappointment along the lines of Dr. Gordon's, it is clear that no other physician was prone to very public verbal diatribes about other physicians or had a practice of calling another physician's patients to comment on that physician's competence or surgical procedure. Moreover, it is unclear whether the Conditions actually imposed extra

obligations on Dr. Gordon. (*See* Def. Ex. 227(A)(1) at Article II, Part A, §§ 1, 2(d)(2) and 4 (stating that "[a]ppointment to the medical staff is a privilege which shall only be extended to professionally competent individuals who continuously meet the qualifications, standards and requirements set forth in this policy and in such policies as are adopted from time to time by the Board" and that only those physicians who can document "adherence to the ethics of their profession" and an "ability to work harmoniously with others" are qualified for staff privileges at the Hospital).) That is, the Conditions of Reappointment merely required Dr. Gordon to comply with the professionalism and competency standards required of physicians in general. If anything, the Conditions simply delineated how the Hospital expected Dr. Gordon to behave for he had demonstrated either a complete disregard for these obligations or a complete ignorance of them. Once Dr. Gordon violated these conditions, the Hospital was obligated, out of professional concerns, to revoke his privileges. On facts eerily similar to those of this case, the Fourth Circuit made the following pronouncement:

> This case illustrates well the dilemma that hospitals face when they consider disciplining a physician by altering his admitting privileges. On the one hand, if the hospital failed to discipline a physician against whom documented complaints were legion, the efficiency of the entire institution could be affected and the hospital could even be exposing itself to malpractice liability. Yet, if the hospital takes corrective action, it and its medical staff face the prospect of a disgruntled physician bringing an antitrust suit against them.

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> In our view, the antitrust laws were not intended to inhibit hospitals from promoting quality patient care through peer review. . . . While we cannot say that no peer review decision would ever implicate the Sherman Act's concern for competition, this assuredly is not such a case. Page Memorial [Hospital] simply took measured steps to discipline an imperious physician. In taking these actions, Page Memorial and its medical staff have [not] violated . . . federal . . . law.

Oksanen v. Page Mem'l Hosp., 945 F.2d 696, 711 (4th Cir.1991).

In short, the court finds that even if Plaintiffs had satisfied their initial burden with respect to every relevant antitrust market in this case, the court would have found that the Hospital met its burden of proving a procompetitive justification for its decision to impose paragraphs 2 and 3 of the Conditions of Reappointment.

3. Plaintiff's Ultimate Burden

Because the Hospital carried its burden under the rule of reason,[45] Plaintiffs bear the ultimate burden of demonstrating that the "restraint is not necessary to achieve the stated objective." *Brown Univ.*, 5 F.3d at 668.

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[45] Of course, the court has already ruled that, with the exception of the market for emergency eye surgery facility services, Plaintiffs failed to meet their initial burden. *See supra* at Part II.A.1.d. The court has included this portion of its opinion merely to illustrate that even if Plaintiffs had met their initial burden, their unreasonable restraint on competition claim would still fail.

At this stage, "[t]he finder of fact must decide whether the questioned practice imposes an unreasonable restraint on competition, taking into account a variety of factors, including specific information about the relevant business, its condition before and after the restraint was imposed and the restraint's history, nature, and effect." *State Oil Co. v. Khan*, 522 U.S. 3, 10, 118 S.Ct. 275, 139 L.Ed.2d 199 (1997). At this stage, "the test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Chicago Bd. of Trade*, 246 U.S. 231, 238, 38 S.Ct. 242, 62 L.Ed. 683 (1918); *see also Martin B. Glauser Dodge Co. v. Chrysler Corp.*, 570 F.2d 72, 82-83 (3d Cir.1977) ("The ultimate test of legality, of course, is whether the particular restraint promotes or impairs competition.").

Plaintiffs contend that Conditions 2 and 3 were overly broad. *See Brown Univ.*, 5 F.3d at 678-79 ("Even if an anticompetitive restraint is intended to achieve a legitimate objective, the restraint only survives a rule of reason analysis if it is reasonably necessary to achieve the legitimate objectives proffered by the defendant.") According to Plaintiffs, "Condition 2 broadly prohibited *any* communication of *any* concern about *any* other doctor or nurse to *anyone* outside of a few specified people." (Pls. Proposed Conclusions of Law at ¶ 67 (emphasis in original).) As such, "Condition 2 would bar Dr. Gordon from telling referring physicians about his concerns with his competitors outdated and risky methods." (*Id.* at ¶ 68.)

However, Condition 2 was not as far sweeping as Plaintiffs claim. Dr. Gordon was not prohibited in any way from commenting upon a particular surgical method to anyone, let alone referring physicians. Instead, Dr. Gordon

was prohibited from making unrestrained comments about particular physicians or nurses. Additionally, to the extent Dr. Gordon claims that associating Dr. Nancollas with ECCE was necessary for Dr. Gordon to obtain referrals, this simply is not true. The optometrists in Lewistown, the primary source of referrals for both Dr. Gordon and Dr. Nancollas, already knew the procedure that each employed. (*See* Tr. (Burns) at 2127-2129; *see also* Tr. (Hutton) at 2160.)

Moreover, Condition 2 did not prohibit Dr. Gordon from registering concerns about quality so long as those complaints were made in writing to those persons with the authority and ability to address the issue. Dr. Gordon may have very well felt that these persons would be unable or unwilling to address his concerns and for that reason disseminated the June 4, 1997 letter to members of the Hospital's Board of Trustees. Yet, Dr. Gordon's belief in this regard was based on nothing more than rank speculation. The fact is, before the June 4, 1997 letter, Dr. Gordon never elected to file a written complaint about Dr. Nancollas. Even this complaint, however, was disruptive to the Hospital's orderly operation because he addressed the letter to over thirty people, including the entire Board of Directors. Because not every medical concern equals a medical crisis, there is no need to copy the Board when a physician raises an ordinary complaint about medical care. Many members of the Board are not physicians and are unable to distinguish between mere complaints and medical issues going to the very core of the Hospital's existence. For this reason, the Hospital sought to channel Dr. Gordon's complaints through the Hospital Administration and the Medical-Dental Staff, the entities charged with overseeing the Hospital's day-to-day operations and

medical issues. This was not an unreasonable requirement, nor was it one which was unique to Dr. Gordon.

Plaintiffs also claim that, "Condition 3 barred *any* communication with *any* patient in the area, at *any* time, if it included *any* comment about another ophthalmologist." (*Id.* at ¶ 71.) Thus, Plaintiffs claim Condition 3 prevented Dr. Gordon from using comparative advertising. However, it is clear that Condition 3 did not prevent Dr. Gordon from advertising because he placed at least two ads while Condition 3 was in effect, one of which laid out the comparative benefits of the phaco procedure over the ECCE procedure. Instead, a reasonable reading of Condition 3 was that it prevented Dr. Gordon from contacting Dr. Nancollas' patients, or any other physician's patients, to tell them that Dr. Nancollas was an inferior physician. This is the purpose and effect of Condition 3. *See Chicago Bd. of Trade*, 246 U.S. at 238 ("[K]nowledge of intent may help the court to interpret facts and to predict consequences.").

Plaintiffs also claim that Conditions 2 and 3 were overly broad because if the Hospital's intention was to curb Dr. Gordon's discourteous conduct, Condition 1 served this end adequately.[46] However, the Hospital did not merely wish to make Dr. Gordon play nicely. The Hospital wanted to channel Dr. Gordon's complaints regarding quality care into appropriate channels and to prevent him

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[46] Condition 1 states the following: "You must treat Hospital personnel and physicians practicing at Lewistown Hospital in a courteous and professional manner. This means that you shall not raise your voice, swear, or in any way demean, belittle, or berate any Hospital personnel or physician practicing at the Hospital." (Def.Ex. 227(A)(11).)

from calling Dr. Nancollas' patients to comment upon Dr. Nancollas' competency. These restrictions were necessary to limit the Hospital's exposure to potential malpractice law suits and to insulate patients' exposure to competition among physicians to appropriate settings. Dr. Gordon did not seem to understand, or refused to comply with, these reasonable limits on his ability to practice medicine at the Hospital. Condition 1 would not make these limitations clear. Conditions 2 and 3, therefore, were necessary to make Dr. Gordon perfectly aware of his obligations with respect to registering internal complaints and contacting patients of other physicians.

Given Dr. Gordon's extensive history of calling and otherwise contacting Dr. Nancollas' patients to comment on his medical competency, Conditions 2 and 3 were not only reasonable, but required Dr. Gordon's reckless remarks exposed the Hospital to potential medical malpractice lawsuits. Moreover, the Hospital's "public service" function also required that the Hospital, to a limited extent, shield patients from the oftentimes harsh realities of capitalistic competition. Hospitals are not only in the business of making money, they also exist to help patients get better. Thus, the Hospital has a vested interest in making sure that patient care takes precedence over physician profit. Policies that enforce this position, however, are not anathematic to business competition. Instead, by regulating the context in which competition occurs, these policies emphasize the Hospital's commitment to quality patient care which, of course, raises esteem for the Hospital among the public, the ultimate consumers of the Hospital's services. *See Weiss,* 745 F.2d at 821 n. 60 (holding that excluding disruptive physicians from a hospital's staff furthers competition and increases

the hospital's efficiency thereby making the hospital a more attractive option to potential consumers).

In this sense, Conditions 2 and 3 furthered the pro-competitive objective of improving the Hospital's service quality. Therefore, the court finds that these restraints on competition, in the end analysis, merely regulate competition and thus are not unreasonable restraints on trade in the relevant antitrust markets. As a result, Plaintiffs' claim in Count I fails, and the court will enter judgment in favor of the Hospital as to that claim.

B. *Count II: Illegal Tying Arrangement*

"Tying is defined as selling one good (the tying product) on the condition that the buyer also purchase another, separate good (the tied product)." *Town Sound and Custom Tops v. Chrysler Motors Corp.*, 959 F.2d 468, 475 (3d Cir.1992) (citing *Bogosian v. Gulf Oil Corp.*, 561 F.2d 434, 449 (3d Cir.1977)). "[C]ertain tying arrangements pose an unacceptable risk of stifling competition and therefore are unreasonable *'per se.'*" *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 9, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984). "It is clear, however, that not every refusal to sell two products separately can be said to restrain competition." *Id.* at 11. With respect to tying arrangements, the Supreme Court has stated that following:

> Our cases have concluded that the essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms. When such "forcing" is present, competition on the merits in

> the market for the tied item is restrained and the Sherman Act is violated.

Id. at 12.

1. *Per Se* Analysis

The Third Circuit has stated that for a tying arrangement to be declared invalid under the *per se* analysis, a plaintiff must prove that (1) the defendant sells two distinct products, (2) the seller possesses market share in the tying product market, and (3) a substantial amount of interstate commerce is affected. *See Brokerage Concepts, Inc. v. U.S. Healthcare,* 140 F.3d 494, 512-13 (3d Cir.1998); *see also Town and Sound Custom Tops,* 959 F.2d at 477. "Where such elements are shown, the defendant's tying practices are condemned without further proof of antitrust injury." *Brokerage Concepts, Inc.,* 140 F.3d at 513; *accord Town and Sound Custom Tops,* 959 F.2d at 477.

In Count II, Plaintiffs claim that the Hospital has tied the provision of its facility services to Dr. Nancollas' physician services. Even assuming the existence of a tie, it is clear that Plaintiffs' claims with respect to the outpatient cataract and inpatient eye surgery markets are not subject to *per se* analysis. *See Town Sound and Custom Tops,* 959 F.2d at 478-79 (holding that *Jefferson Parish* established that only when the plaintiff has proven market power in the tying product market may the court subject the defendant to *per se* liability). As stated above, Plaintiffs have failed to demonstrate that the Hospital possesses market power with respect to those markets. *See supra* at Parts II.A.1.b. Thus, Plaintiffs' claims with respect to these markets are more properly analyzed under the rule of reason test. *See infra* at Part II.B.2.

However, Plaintiffs' have proved that the Hospital possessed market power in the market for emergency eye surgery facility services market. *See supra* at Part II.A.1.b. Therefore, Plaintiffs will prevail on their claim regarding emergency eye surgery services if they proved that (1) the Hospital tied the provision of emergency eye surgery facility services to the patient's use of Dr. Nancollas to provide those services, and (2) that tie affected a substantial amount of interstate commerce. *See Town Sound and Custom Tops,* 959 F.2d at 477 (holding that if the plaintiff satisfies the three-part *per se* tying test, "then the defendant's tying practices are automatically illegal without further proof of anticompetitive effect").

To be classified as having a substantial effect on interstate commerce, a tie must be "substantial enough in terms of dollar volume so as not to be merely *de minimis.*" *Fortner Enters. v. U.S. Steel,* 394 U.S. 495, 501, 89 S.Ct. 1252, 22 L.Ed.2d 495 (1969) (citations omitted). With respect to the effect of Dr. Gordon's exclusion on interstate commerce, Plaintiffs contend that courts have treated as substantial ties whose effect measured as little as $10,091.07. *See Tic X-Press, Inc. v. Omni Promotions Co. of Ga.,* 815 F.2d 1407, 1419 (11th Cir.1987).

In this case, however, Plaintiffs have presented absolutely no evidence whatsoever regarding the dollar volume effect in the allegedly tied market: emergency eye surgery physician services.[47] At trial, Plaintiffs presented

[47] The court has already recognized that the Hospital is engaged in business affecting interstate commerce. *See supra* at Part I.A. Yet, this does not relieve Plaintiffs' obligation to prove that the alleged tying arrangement affected a substantial amount of interstate commerce in the relevant tied market.

anecdotal evidence regarding two patients who, subsequent to Dr. Gordon's exclusion, sought out emergency eye treatment at the Hospital and were forced to use Dr. Nancollas or to seek treatment at hospitals in distant locales.[48] However, only one of these patients, William Hawk, actually received what can be classified as an emergency eye surgery procedure; the product market that Plaintiffs allege has been tied. Plaintiffs presented no evidence about how much either of these patients were charged for the physician services they received. Likewise, Plaintiffs presented absolutely no other evidence regarding how much dollar volume business has been affected by the Hospital's alleged tie. Given that the Plaintiffs have failed to present any such evidence regarding this matter, the court cannot rightly say that the Hospital's alleged tie affected a substantial amount of interstate commerce. Accordingly, Plaintiffs' claim regarding the Hospital's alleged tying of the facilities and physician services markets for emergency eye surgery fails the *per se* analysis and must be analyzed under the rule of reason.

2. Rule of Reason Analysis

Unlike a *per se* case – where if the plaintiff satisfies the required elements, the court infers that the defendant is using its market power in the tying market to expand into the tied market – to succeed under the rule of reason, the plaintiff must prove (1) a tying arrangement, and (2) an injury to competition. *Brokerage Concepts,* 140 F.3d at 519 (quoting *Jefferson Parish,* 466 U.S. at 29). Of course,

[48] Beverly Hawk, however, testified only as to the treatment rendered to her husband, William Hawk. This makes no difference. The court finds her testimony credible.

the plaintiff must also prove that the defendant's alleged tie caused the injury to competition. *See Town and Sound Custom Tops,* 959 F.2d at 486-87 ("A plaintiff must link the two showings with a theory of causation that is both plausible and cognizable by the anti-trust laws.").

Above, the court has already held that no injury to competition occurred in either the markets for outpatient cataract surgery and inpatient eye surgery physician services markets. *See supra* at Part II.A.1.c. Moreover, to the extent any injury to competition occurred in any of the relevant physician services markets, the Conditions of Reappointment did not proximately cause it. *Id.* Additionally, the court has held that even if the court were to find that Plaintiffs met their initial burden under the rule of reason, the Hospital met its burden of demonstrating that the decision to impose the Conditions of Reappointment served pro-competitive justifications. *See supra* at Part II.A.2. Similarly, the decision to revoke Dr. Gordon's staff privileges for violating the Conditions also serves the same pro-competitive justification. *Id.* Finally, the court held that the Hospital's decision to impose the Conditions of Reappointment, on the whole, furthered, rather [sic] hindered competition. *See supra* at Part II.A.3.

Essentially, the court's holding regarding Count I are equally applicable to the rule of reason analysis of Plaintiffs' tying claim in Count II. The court sees no reason to rehash them in what is already a lengthy opinion. The court, however, will say that whatever tying arrangement occurred in this case was unintentional and did not injure competition in any of the relevant markets. To the extent any injury to competition occurred, such injury is attributable to Dr. Gordon's conduct, not the Hospital's decision to impose the Conditions of Reappointment and, ultimately,

to exclude Dr. Gordon from the Medical-Dental Staff. Finally, even if Plaintiffs proved an injury to competition based on the Hospital's decisions to impose the Conditions of Reappointment and to exclude Dr. Gordon, those decisions were justified by pro-competitive motivations which on the whole furthered, rather than hindered, competition in the relevant markets. Thus, Plaintiffs' claim in Count II must fail, and the court will grant judgment in favor of the Hospital on that claim.

C. *Count III: Attempted Monopolization*

In Count III, Plaintiffs claims that the Hospital attempted to monopolize the general outpatient cataract surgery market in violation of Section 2 of the Sherman Act. *See* 15 U.S.C. § 2.[49] To prevail on a claim of attempted monopolization, "a plaintiff must prove (1) that the defendant has engaged in predatory or anticompetitive conduct with (2) a specific intent to monopolize and (3) a dangerous probability of achieving monopoly power." *Spectrum Sports, Inc. v. McQuillan,* 506 U.S. 447, 456, 113 S.Ct. 884, 122 L.Ed.2d 247 (1993).

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[49] Section 2 of the Sherman Act reads as follows:

> Every person who shall monopolize, or attempt to monopolize or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among the several States, or with foreign nations, shall be deemed guilty of a felony, and, on conviction thereof, shall be punished by fine not exceeding $10,000,000 if a corporation, or, if any other person, $350,000, or by imprisonment not exceeding three years, or by both said punishments in the discretion of the court.

15 U.S.C. § 2. Of course, a private party may sue to enforce the provisions of the Sherman Act. *See LePage's Inc. v. 3M,* 324 F.3d 141, 146 (3d Cir.2003).

The court finds that Plaintiffs' Section 2 claim must fail because they have failed to convince the court that the Hospital acted with a specific intent to monopolize any of the relevant antitrust markets at issue in this case. Instead, the court finds that the Hospital acted to discipline a persistently obstreperous physician who stubbornly refused to comply with the standards of courtesy and professionalism expected of a medical doctor. The Hospital did not seek, through its discipline of Dr. Gordon, to achieve a monopoly in the outpatient cataract surgery facility services market or to give Dr. Nancollas extra business in the physician services component of this market due to his affiliation with Geisinger. Instead, the Hospital had reached its breaking point and sought to rid itself of a physician whose conduct was detrimental to Hospital staff morale. To the extent Plaintiffs argue that certain conduct by McAleer – that is, his conversations with Dr. Powers and Dr. Cillo – demonstrates either a specific intent to monopolize or predatory conduct, the court finds that McAleer's motivation was more likely a personal dislike for Dr. Gordon, rather than a fear that he would rob the Hospital of its market share for outpatient cataract surgery services.[50]

Because, on the whole, the evidence did not demonstrate that the Hospital specifically intended to monopolize, Plaintiffs' claim in Count III must fail. The court, therefore, need not further discuss the other elements of

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[50] Moreover, McAleer did not join the Hospital Administration until March 30, 1998. (*See* Def. Ex. 557 at p. 5, Ins. 1-4.) Therefore, he did not take part in the decisions to impose the Conditions of Reappointment and to ultimately exclude Dr. Gordon from the Medical-Dental Staff.

this claim. Specific intent to monopolize is a required element, and failure to prove it is fatal to Plaintiffs' Section 2 claim. Accordingly, the court will enter judgment in favor of the Hospital on Count III.

D. *Other Pending Motions*

On November 12, 2002, the Hospital filed a motion to strike Plaintiffs' proposed findings of fact and conclusions of law. On December 20, 2002, the Hospital filed an identical motion with respect to Plaintiffs' supplemental proposed findings of fact and conclusions of law. Because the court will enter judgment in favor of the Hospital on all counts, it need not address the Hospital's motions. Accordingly, the court will deny, as moot, the Hospital's motions to strike.

E. *Evidentiary Matters*

At trial, the court deferred ruling on the admissibility of fifty-two Hospital exhibits. Plaintiffs objected to the introduction of these exhibits on the basis that their introduction would violate the court's order of November 8 which limited what evidence would be admissible with regards to Dr. Gordon's disciplinary history at the Hospital. Specifically, that order indicated that to avoid conducting mini-trials regarding Dr. Gordon's conduct, the court would limit introduction of Dr. Gordon's disciplinary history to those events occurring after 1990, so long as that evidence related to the concerns addressed by paragraphs 2 and 3 of the Conditions of Reappointment. *See Gordon v. Lewistown Hosp.*, No. 1:CV-99-1100, order (Nov. 8, 2001); *see also id.*, order at ¶ 5 (April 2, 2002).

After reviewing these exhibits, the court finds that thirteen of these exhibits are irrelevant and their admission would be inconsistent with the court's previous rulings. (*See* Def. Exs. 226(A)(20 and 25), 226(J)(2-5), 231(19), (24), (28), (34), (37), (38), and (39).) Additionally, Plaintiffs relied upon three of the "reserved" exhibits in either their original or supplemental proposed findings of fact and conclusions of law. (*See* Def. Exs. 227(A)(6), (7), and (9).) By relying on these exhibits, Plaintiffs waived any objection to their admission. Accordingly, the court will admit those exhibits. As to the remaining thirty-six exhibits, the court finds that these exhibits are relevant and admissible for at least some limited purpose. (*See* Def. Exs. 226(A)(6 and 7), (15-18), (33), (35), (45), (50), (52), 226(I), (J)(1), 227(A)(1), (A)(8), (10-20), (E), (H), (I), (J)(3 and 5), 231(2, 10, 21, 29, and 40.) Thus, the court will admit these exhibits into the record.

III. *Conclusions of Law*

1. The following exhibits are admitted into the record: Def. Exs. 226(A)(6 and 7), (15-18), (33), (35), (45), (50), (52), 226(I), (J)(1), 227(A)(1), (6-20), (E), (H), (I), (J)(3 and 5), and 231 (2, 10, 21, 29, and 40).

2. The following exhibits are excluded from the record: Def. Exs. 226(A)(20 and 25), 226(J)(2-5), 231(19), (24), (28), (34), (37), (38), and (39).

3. The court's subject matter jurisdiction is based on 28 U.S.C. § 1331.

4. Plaintiffs failed to meet their burden of demonstrating that the Hospital's decision to impose the Conditions of Reappointment constituted an unreasonable

restraint on trade in violation of Section 1 of the Sherman Act. *See* 15 U.S.C. § 1.

5. Plaintiffs failed to meet their burden of demonstrating that the Hospital's decision to impose the Conditions of Reappointment and to ultimately exclude Dr. Gordon from the Hospital's Medical-Dental Staff constituted an illegal tying arrangement in violation of Section 1 of the Sherman Act. *See id.*

6. Plaintiffs failed to meet their burden of demonstrating that the Hospital's actions constituted an attempt to monopolize the general outpatient cataract surgery services market in violation of Section 2 of the Sherman Act. *See id.* at § 2.

7. As Plaintiffs failed to prove a violation of the Sherman Act, they are not entitled to any form of injunctive relief. An appropriate order will follow.

Not Reported in F.Supp.2d

United States District Court,
M.D. Pennsylvania. Alan D. GORDON, M.D.; Alan D. Gordon, M.D., P.C.; Mifflin County Community Surgical Center, Inc., Plaintiffs
v.
LEWISTOWN HOSPITAL, Defendant
No. Civ.1:CV-99-1100.

May 21, 2001.

George M. Sanders, Steven B. Varick, Holland & Knight LLC, Henry S. Allen, Jr., Robert W. Queeney, McBride, Baker and Coles, Chicago, IL, John B. Huck, Bluffton, SC, Orris C. Knepp, III, Knepp and Snook, Lewistown, PA, for Plaintiff.

Jonathan B. Sprague, Kathleen Chancler, Mark L. Mattioli, Post & Schell, Philadelphia, PA, Susan M. Lapenta, Horty, Springer & Mattern, Pittsburgh, PA, for Defendant.

MEMORANDUM

RAMBO, J.

Before the court are cross-motions for summary judgment. Plaintiffs seek summary judgment with respect to Count I of the amended complaint and Defendant's first and fourteenth affirmative defenses. Defendant seeks summary judgment on all of Plaintiffs' claims. The parties have briefed the issues, and the motions are ripe for disposition.

I. *Background*

A. *Factual Background*

The following facts are undisputed except where otherwise noted: On February 2, 2000, Plaintiffs filed an amended complaint against Defendant Lewistown Hospital (the "Hospital"), alleging violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2. Plaintiff Dr. Alan Gordon is an ophthalmologist who joined the staff of the Hospital in 1980. Dr. Paul Nancollas is an ophthalmologist who is employed by the Geisinger Medical Group – Lewistown ("Geisinger"). Dr. Nancollas and Dr. Gordon were the only two ophthalmologists on staff at the Hospital in 1997, and both performed cataract surgeries. However, Dr. Gordon and Dr. Nancollas employ different procedures for cataract removal. Dr. Nancollas usually performs what is called an extracapsular cataract extraction ("ECCE"), while Dr. Gordon performs a phacoemulsification procedure ("phaco procedure"). Relying upon expert reports and depositions, Plaintiffs describe ECCE as follows:

> [Dr. Nancollas's] incision was large, not self-sealing, and required sutures for closure. He achieved anesthesia by giving the patient a periocular block and a facial block while they were under heavy intravenous sedation. He implanted a large (7 mm) rigid PMMA intraocular lens. This procedure, as done by Dr. Nancollas, took an average one and three quarter hours to complete.

(Pl. Br. Supp. Mot. Summ. Jud., "Pl. Supp. Br." at 5) (citing Silverstone Decl., Report at 5-6; Burns Dep. at 38-41, 54-58; Nancollas Dep. at 145-56; Pl.Ex. 173; Pl.Ex. 41).) Plaintiffs also note various complications that can occur during the ECCE procedure as a result of both the procedure itself and the type of anesthesia used. These complications include

infection, hemorrhaging, increased astigmatism and optical distortion, wound separation, and the prolapse of ocular contents, as well as vision and life-threatening complications from the anesthesia itself. (*Id.*)

The phaco procedure used by Dr. Gordon involves a posterior limbal incision with a 3 millimeter self-sealing multiplane incision, which is followed by removal of the lens by phacoemulsification. Next a foldable intraocular lens is placed into the lens capsular bag. The phaco procedure takes 24-28 minutes, and sutures are not usually necessary. Dr. Gordon usually used only a topical anesthesia while performing the surgery. Finally, Plaintiffs note that the ECCE procedure "has been steadily replaced nationally and internationally by the [phaco] procedure." (*Id.* at 6.)

In 1996 Dr. Gordon's clinical privileges at the Hospital were suspended for 45 days (the "1996 suspension"). Then, in the fall of 1997, the Hospital revoked Dr. Gordon's clinical privileges and made Dr. Gordon ineligible to reapply for appointment and clinical privileges for a period of five years (the "1997 revocation"). The instant action arises out of the 1996 suspension and the 1997 revocation.

The Hospital recites a long history of disciplinary action with regard to Dr. Gordon.[1] On October 24, 1985, Carl Spease, D.O., the President of the Medical-Dental staff, informed Dr. Gordon that the Medical Executive

[1] The Hospital begins its recitation of the facts with a reprimand that occurred in 1984 which the court will not consider. The reprimand involved a medically related practice of Dr. Gordon's, and Defendant has here conceded that Dr. Gordon's competence is not at issue. (Def. Stat. Mat. Facts at ¶ 118.) Accordingly, the 1984 incident is irrelevant to the instant litigation.

Committee ("MEC") had received a request for corrective action as a result of Dr. Gordon's disruptive behavior. (Exs. to Def. Br. in Supp. Mot. Summ. Jud. ("Def.Supp.Ex."), Ex. E.) The Hospital's Credentials Committee eventually proposed that Dr. Gordon be placed on probation for one year with various conditions of probation to be met during that time. Dr. Gordon requested a hearing on the probation.

Dr. Gordon was informed of the alleged events forming the basis of the Credentials Committee's recommendation. These allegations included the following: (1) on May 7, 1985, Dr. Gordon verbally attacked another physician in a public hallway of the Hospital, using loud and profane language; (2) on August 9, 1985, Dr. Gordon verbally attacked two other physicians in the Intensive Care Unit of the Hospital, using loud and profane language within earshot of patients and other employees; (3) on August 30, September 6, and October 9, 1985, in front of patients Dr. Gordon confronted a nurse who had witnessed one of the above incidents. Dr. Gordon asked the nurse what she had reported about the incident. The nurse was intimidated by Dr. Gordon and requested to be transferred in order to avoid further confrontations; (4) Dr. Gordon called a patient several times during August 1985 regarding her decision to see another ophthalmologist. During the course of these conversations, Dr. Gordon cast doubt on the qualifications of members of the medical staff and accused one member of the staff of improper financial practices; (5) Dr. Gordon had been warned in the past about disruptive behavior. (Def.Supp.Ex. F.)

On December 4, 1985, a Fair Hearing Committee was convened under § 9.2.1 of the Medical Staff Bylaws. Following the hearing, the committee concluded that Dr.

Gordon had "engaged in, made, or exhibited acts, statements, demeanor or unprofessional conduct that is reasonably likely to be detrimental to the delivery of good patient care, or reasonably likely to be disruptive of Hospital operations" (Def.Supp.Ex. I.) The committee also found that Dr. Gordon had verbally attacked one physician, had upset a nurse with his questioning, and that the patient he had repeatedly contacted felt harassed to the point of writing a letter to the President of the Hospital. The Hospital's Board of Trustees (the "Board") placed Dr. Gordon on six months of probation with the following conditions: (1) Dr. Gordon cease "[p]ublic verbal assaults, including profanity, of [Hospital] Staff members;" (2) Dr. Gordon cease harassment of Hospital staff members that would be "reasonably likely to be detrimental to good patient care or disruptive to hospital operations." (Def.Supp.Ex. K, L.) Dr. Gordon did not appeal the probation. (Def.Supp.Ex. L.) Following an investigation into a violation of Dr. Godon's conditions of probation, the Board extended the probation until August 1, 1987, and required him to enter a program of psychotherapy. (Def.Supp.Ex. N.)

Defendant has also introduced evidence of a conversation that took place between Marcia Stewart, R.N., the Hospital's Associate Director of Nursing on January 8, 1992, and Dr. Gordon. (Def.Supp.Ex. R.) Ms. Stewart wanted to discuss with Dr. Gordon his relationship with the nursing staff. Ms. Stewart requested that Dr. Gordon not discuss non-patient related information with the nursing staff, and proceeded to allow nurses to voice complaints specifically to Dr. Gordon. Ms. Stewart cut the conversation between Dr. Gordon and the nurses short because she felt that "Dr. Gordon was not acknowledging

the R.N.s[']s concerns and continued to relay inappropriate information to them." (*Id.*) Dr. Gordon then referred to Ms. Stewart as a "brainless airhead," and pointing to his own temples, stated "you have nothing between here." (*Id.*)

In response to the events of January 8, 1992, Richard Scanlon, D.M.D., then President of the Hospital's Medical-Dental Staff wrote Dr. Gordon. (Def.Supp.Ex. U.) Dr. Scanlon stated that "[a]ny further behavior in Lewistown Hospital judged disruptive by [various Hospital administrators] will result in the immediate cancellation of your surgical schedule until you and the other parties involved in the disruptive behavior resolve the problem in an appropriate and private location." (*Id.*) Further disruptive behavior could result in a summary suspension of Dr. Gordon's staff privileges. Finally, Dr. Scanlon warned Dr. Gordon that if any staff member felt as though he or she was being harassed outside of work, "an appropriate restraining order from the Mifflin County Court may be sought." (*Id.*) Dr. Scanlon explained that he felt this action was necessary to "insure a peaceful environment for the nurses, patients, and visitors of Lewistown Hospital." (*Id.*)

In response to a request from Michael Fishter, the Chairman of the Department of Neuropsychiatry, Michael K. Huff who was the Director of Nursing Services at the Hospital in 1992 wrote a letter containing his impression of the impact of Dr. Gordon's behavior on the nursing staff. (Def.Supp.Ex. V.) Mr. Huff concluded that Dr. Gordon's "frequent disregard for Hospital and Nursing policies and procedures compromise not only the nursing care being provided, but place the staff in the position of always being on the offensive. . . . As a result the nursing staff will resort to hiding information and avoid unnecessary conversations with [Dr. Gordon] for fear it will be a catalyst to

his loud agitated behaviors. To quote one of the Same Day Surgery nursing staff, 'Every day we work with him its like sitting on a time bomb waiting for it to go off.'" (*Id.*)

On February 13, 1992, Daniel Creighton, M.D., then Chairman of the Hospital's Credentials Committee, sent Dr. Gordon a letter. (Def.Supp.Ex. W.) Dr. Creighton informed Dr. Gordon that the Committee had found that "many of your documented behaviors are and have been: disruptive to the orderly operation of the Hospital, demoralizing to Hospital Personnel, and detrimental to the unity of the Medical-Dental Staff and the quality of patient care at this Hospital." (*Id.*) Dr. Creighton informed Dr. Gordon that the next time Dr. Gordon engaged in disruptive behavior that was brought before the Committee and substantiated, the Committee would recommend Dr. Gordon's suspension from the medical staff.

A nurse on duty in the emergency room on July 14, 1992, documented an event that took place on that day. The nurse states that Dr. Gordon screamed, "Who do you think you are? I think you're some f* * *ing bitch just trying to throw a wrench in the works." (Def.Supp.Ex. X.) Dr. Gordon's clinical privileges were revoked for 28 days as a result of this incident. (Gordon Dep. at 31.)

On November 29, 1995, the Credentials Committee again recommended that Dr. Gordon's clinical privileges be suspended, this time for 45 days. (Def.Supp.Ex. 1.) Dr. Gordon requested a hearing regarding this suspension which the Hospital provided. Dr. Gordon was represented by counsel, and the Hearing Officer heard three days of testimony and evidence. (*Id.*) Following the hearing, the Hearing Officer issued a Recommendation and Report in which she recommended that the Committee's proposal of

a 45 day suspension be affirmed. The Hearing Officer found as follows: first, Dr. Gordon precipitated a confrontation about Geisinger between himself and another physician, Dr. Qureshi, on June 19, 1995, in the presence of a patient. The Hearing Officer also concluded that the confrontation and its effects were "unacceptable and disruptive." (*Id.* at 2.) Furthermore, the Hearing Officer noted that "Dr. Gordon's concerns about Geisinger and medical economics, real or perceived, do not excuse such conduct." (*Id.* at 2.)

The Hearing Officer also found that Dr. Gordon had expressed himself to a nurse in the same day surgery unit on August 24, 1996, in an unacceptable manner. "Dr. Gordon stated, in a loud angry voice that the nurse 'didn't give a damn about the patients' and that she 'is a trouble maker and always has been' and that 'you are all assholes.'" (*Id.*) Again, the Hearing Officer concluded that regardless of whether Dr. Gordon's concerns were real or perceived, they were addressed inappropriately.

Finally, the Hearing Officer was presented with evidence and testimony regarding a series of telephone calls that Dr. Gordon made to cataract patients of Dr. Nancollas and/or their family members during the period of June 1994 through April 1995, some of which were made the night before the patients were scheduled for surgery. (*Id.* at 3.) Dr. Gordon testified that the purpose of these calls was to warn the patients about Dr. Nancollas. Dr. Gordon acknowledged that these calls would increase the patients' anxiety, and that they could do little or nothing the night before surgery to explore other alternatives. The Hearing Officer concluded that "[t]hese phone calls show extremely poor judgment, and are . . . cruel to the patient about whom Dr. Gordon professes to care." (*Id.*)

Again, the Hearing Officer noted that the issue was not whether Dr. Gordon's concerns were real or not, but "the manner in which Dr. Gordon has chosen to express his concerns is unacceptable and disruptive to the Hospital." (*Id.*) Dr. Gordon sought reconsideration of the Hearing Officer's decision regarding the suspension which the Hearing Officer denied. (Def. Supp. Ex. 17; Gordon Dep. at 129.) Dr. Gordon did not appeal the 45 day suspension to the Hospital's Appeal Review Panel, and the suspension concluded on August 20, 1996.

During this period, the Hospital had before it a pending application for Dr. Gordon's staff reappointment for the period of February 1, 1995 to January 31, 1997. (Def.Supp.Ex. 14.) As the above described events unfolded, the Credentials Committee considered denying Dr. Gordon's application for reappointment. (Def. Supp. Ex. 19; Gordon Dep. at 144-46.) Dr. Gordon made assurances to the Credentials Committee that he had found his phone calls to patients to be counterproductive and that it was his intent not to call or communicate "with the patients of any other ophthalmologist for the purpose of commenting on that physician's training, skill or competency or the procedure performed by such physician." (Def.Supp.Ex. 20.)

In a letter dated September 30, 1996, the Credentials Committee of the Hospital made Dr. Gordon's reappointment to the medical staff contingent upon 17 Conditions for Reappointment. (Def.Supp.Ex. 21.) Dr. Gordon agreed to the Conditions for Reappointment. At issue in the instant litigation are Paragraphs 2 and 3 of the Conditions for Reappointment, which require the following:

(2) You must use appropriate administrative channels to register any complaint or concern that you might have about others practicing at the Hospital. Specifically, any complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Credentials Committee, with a copy to the President of the Hospital. Any complaint or concern about any nursing personnel shall be reported in writing to that individual's supervisor, with a copy to the President of the Hospital. Any other complaint or concern about scheduling, equipment or any other matter must be in writing directed to the President of the Hospital;

(3) You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician. Furthermore, other than in response to a specific question or for the purpose of a referral, you shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

(*Id.*)

One of the two events leading to the 1997 revocation of Dr. Gordon's clinical privileges was a telephone call that he made to a woman by the name of Margaret Seecora. Dr. Gordon began treating Mrs. Seecora for cataracts on July 22, 1994. On October 18, 1995, Dr. Gordon's office contacted

Mrs. Seecora as a "follow-up" to her last appointment in September. Dr. Gordon's office sent Mrs. Seecora a re-call card on January 4, 1996, and then telephoned her on August 26, 1996. The same year, 1996, Mrs. Seecora enrolled in Geisinger Health Plan and began to see Dr. Nancollas. Mrs. Seecora had a cataract removed from one eye in March 1997 by Dr. Nancollas. Dr. Gordon called Mrs. Seecora in June 1997 and learned that she was Dr. Nancollas's patient and that Dr. Nancollas had removed one of her cataracts.

The content of the conversation between Dr. Gordon and Mrs. Seecora is in dispute. Dr. Gordon contends that he "discussed with Mrs. Seecora the difference between the cataract procedure as done by Dr. Nancollas and the cataract procedure as done by Dr. Gordon, including the benefits of topical anesthesia, modern cataract surgery and soft interocular lenses." (Pl. Stat. Mat. Facts at ¶ 26.) Dr. Gordon has also testified that he listed for Mrs. Seecora all of the "unnecessary risks" that she went through in having Dr. Nancollas remove her cataract, told her that he personally disliked Dr. Nancollas, and told her that she had been misled and uninformed. (Gordon Dep. at 136-39.) Also in dispute is whether Dr. Gordon contacted Mrs. Seecora for the purpose of getting her to use his services. While Plaintiffs assert that this was Dr. Gordon's intent (Pl. Stat. Mat. Facts at ¶ 28), Defendant notes that Dr. Gordon testified to the contrary before a Hearing Officer on August 22, 1997.[2] Defendant also cites the contents of a letter written to the Chairman of the Credentials Committee

[2] Specifically, Defendant points to Dr. Gordon's statement that Mrs. Seecora did not have to see him for medical services but that he could refer her to many fine ophthalmologists. (Def. Supp. Ex. 25 at 136-37.)

following the incident in which he stated that he told Mrs. Seecora that he could refer her to other ophthalmologists. While Dr. Gordon contends that he had an obligation to provide this information to Mrs. Seecora because of an existing doctor-patient relationship, Defendant notes that Dr. Gordon has acknowledged that he did not necessarily perceive Mrs. Seecora as his patient and that he had not treated her since September 1994 but made the call in June 1996. Mrs. Seecora's daughter, Jean Eckley, reported the telephone call to the Hospital's President. Mrs. Seecora was intimidated by Dr. Gordon was upset by the phone call, and considered it unprofessional. (Seecora Dep. at 32, 38, 49-53.)

The other event that eventually lead to the 1997 revocation occurred on June 4, 1997, when Dr. Gordon mailed a letter to approximately 30 members of the Hospital's Board, the Hospital's Credentials Committee, and the Hospital's administration. (Def.Supp.Ex. 24.) In that letter, Dr. Gordon expressed what he labeled "unnecessary" risks associated with the cataract procedure utilized by Dr. Nancollas. (*Id.*) In his letter, Dr. Gordon stated that he was "informed that the hospital administration and the credentials committee is interested in all 'potential risks to patients,'" and that the letter was "sent on the request of the administration who notified [Dr. Gordon] that if [he] did have concerns, [he] should put them in writing rather than just verbally discussing them with the administration." (*Id.*)

On July 15, 1997, the Chairman of the Credentials Committee requested that Dr. Gordon meet with the Committee to discuss the call to Mrs. Seecora and the letter that Dr. Gordon had sent. Dr. Gordon and his attorney met with the Credentials Committee on July 17,

1997. The next day the Chairman of the Committee informed Dr. Gordon that the Committee had concluded that the Conditions of Reappointment had been violated and that Dr. Gordon would be excluded from the Hospital after July 23, 1997. Dr. Gordon also received notice that the Credentials Committee had recommended that his appointment and clinical privileges be revoked and Dr. Gordon be ineligible to reapply for such privileges for a period of five years. The telephone contact with Mrs. Seecora and the letter sent to the Hospital administration were found to violate Paragraphs 2 and 3 of the Conditions of Reappointment.

On August 22, 1997, at Dr. Gordon's request, a Fair Hearing was held to address the Credentials Committee's recommendation. On September 25, 1997, the Hearing Officer issued a Recommendation and Report that affirmed the Committee's recommendation regarding the revocation of Dr. Gordon's appointment and clinical privileges. Dr. Gordon requested appellate review of the Hearing Officer's decision. On November 24, 1997, the Appellate Review Panel issued a Recommendation and Report agreeing with the Hearing Officer's conclusions. On November 25, 1997, the Board informed Dr. Gordon that it had adopted the Credentials Committee's recommendation.

B. *Procedural Background*

On June 25, 1999, Plaintiffs filed an antitrust action against various Defendants, including the Hospital. On February 2, 2000, an amended complaint was filed, and only the Hospital was named as a Defendant. In addition to Dr. Gordon himself, Plaintiffs include Alan D. Gordon,

M.D., P.C., a Pennsylvania professional corporation organized in 1981, and Mifflin County Community Surgical Center, Inc. ("MCCSC"), a Pennsylvania Corporation organized in 1998. Dr. Gordon is the sole stockholder of both of these corporations.

Plaintiffs' amended complaint states eight causes of action under the Sherman Act, 15 U.S.C. §§ 1-2. Plaintiffs' claims under Section 1 include contract in restraint on trade (Count I); illegal tying arrangement (Count II); reciprocal dealing (Count IV); boycott (Count V); and exclusive dealing (Count VI). Plaintiffs' claims under Section 2 are attempted monopolization (Count III); and conspiracy to monopolize (Counts VII and VIII). Defendant answered Plaintiffs' amended complaint with eighteen affirmative defenses. Plaintiffs place the First and Fourteenth affirmative defenses at issue in the present motion for summary judgment. These defenses are that Defendant is immune from liability under the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* ("HCQIA") (first affirmative defense) and that Plaintiffs' claims are frivolous, unreasonable, without foundation, and/or in bad faith, thereby entitling the Hospital to all costs and attorneys fees pursuant to 42 U.S.C. § 11113 (fourteenth affirmative defense).

II. *Legal Standard: Motion for Summary Judgment*

Federal Rule of Civil Procedure 56 provides that summary judgment is proper when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law."

A factual dispute is "material" if it might affect the outcome of the suit under the applicable law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). A factual dispute is "genuine" only if there is a sufficient evidentiary basis which would allow a reasonable fact-finder to return a verdict for the non-moving party. *Id.* at 249. The court must resolve all doubts as to the existence of a genuine issue of material fact in favor of the non-moving party. *Gans v. Mundy*, 762 F.2d 338, 340 (3d Cir.1985), *cert. denied*, 474 U.S. 1010, 106 S.Ct. 537, 88 L.Ed.2d 467 (1985).

Once the moving party has shown that there is an absence of evidence to support the claims of the non-moving party, the non-moving party may not simply sit back and rest on the allegations in the complaint; instead, it must "go beyond the pleadings and by [its] own affidavits, or by the depositions, answers to interrogatories, and admissions on file, and designate specific facts showing that there is a genuine issue for trial." *Celotex Corp. v. Catrett*, 477 U.S. 317, 324, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986) (internal quotations omitted). Summary judgment should be granted where a party "fails to make a showing sufficient to establish the existence of an element essential to that party's case and on which that party will bear the burden at trial." *Id.*

The standards governing the court's consideration of Federal Rule 56(c) cross-motions are the same as those governing motions for summary judgment, although the court must construe the motions independently, viewing the evidence presented by each moving party in the light most favorable to the nonmovant. *Raymond Proffitt Found. v. U.S. Envt'l. Protection Agency*, 930 F.Supp. 1088, 1096 (E.D.Pa.1996).

III. *Discussion*

A. *Plaintiffs' Motion*

Plaintiffs move for summary judgment on Count I of their amended complaint as well as Defendant's first and fourteenth affirmative defenses.

1. *Count I*

In Count I of their amended complaint, Plaintiffs allege that:

> The Hospital engaged in various contracts, combinations and conspiracies . . . whereby Dr. Gordon was required to enter into a November, 1996 gag contract that prevented Dr. Gordon from competing to retain or obtain business by communicating truthful non-deceptive information to patients relevant to their surgical decisions, including their choice of ophthalmologist, foreclosed by Dr. Gordon from supplying services in the relevant physician opthalmic surgical markets, and created an unreasonable restraint of trade, all in violation of Section 1 of the Sherman [Act], 15 U.S.C. Section 1.

(Amend.Compl.¶ 47.) The alleged "contracts, combinations and conspiracies" were between the Hospital and two co-conspirators, Geisinger and Robert P. Postal. (*Id.*) Geisinger is a Pennsylvania corporation that provides health insurance and physician services to individuals. Robert P. Postal is the Chairman of the Lewistown Hospital Board and the Chairman of the Mifflin County Industrial Development Authority. (*Id.* at ¶¶ 5-6.)

Plaintiffs contend that the Conditions of Reappointment, discussed in *supra* section I.A., constitutes a "gag

contract" that resulted in "Dr. Gordon's inability to inform patients of the comparative advantages of his cataract removal procedure and associated anesthesia to that employed by Dr. Nancollas." (Pl. Br. Supp. Mot. for Summ. Jud., "Pl. Supp. Br." at 11.) Section 1 of the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal." 15 U.S.C. § 1. However, the Supreme Court has recognized that "even beneficial business contracts or combinations restrain trade to some degree" and therefore Section 1 prohibits only contracts or combinations that are *unreasonable* restraints on trade. *United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir.1993) (citing *Standard Oil. Co. v. United States*, 221 U.S. 1, 58, 31 S.Ct. 502, 55 L.Ed. 619 (1911)).

Relying on Supreme Court case law, the Third Circuit has enumerated three different tests to determine whether a business combination constitutes an unreasonable restraint on trade in violation of Section 1. *Id.* Pursuant to the traditional "rule of reason," the fact-finder must look at the totality of the circumstances in order to ascertain whether a practice violates Section 1. *Id.* (citing *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 36, 49, 97 S.Ct. 2549, 53 L.Ed.2d 568 (1977)). "The plaintiff bears an initial burden under the rule of reason of showing that the alleged combination or agreement produced adverse, anti-competitive effects within the relevant product and geographic markets." *Id.* However, because proof of actual anti-competitive effects is often impossible to make, courts allow a plaintiff to present proof of the defendant's market power to satisfy its initial burden. *Id.* (citing *NCAA v. Bd. of Regents of the Univ. of Oklahoma*, 468 U.S. 85, 110, 104

S.Ct. 2948, 82 L.Ed.2d 70 (1984) (herinafter [sic] "*Univ. Oklahoma*")).

Once a plaintiff has successfully met its initial burden under the traditional rule of reason, the burden then shifts to the defendant to "show that the challenged conduct promotes a sufficiently pro-competitive objective." *Id.* at 669. Finally, the burden shifts back to the plaintiff, wherein the plaintiff must show that the "restraint is not necessary to achieve the stated objective." *Id.* In sum, under the rule of reason "the test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition." *Fed. Trade Comm'n v. Indiana Federation of Dentists,* 476 U.S. 447, 458, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986) (hereinafter "*IFD*") (citing *Chicago Bd. of Trade v. United States,* 246 U.S. 231, 238, 38 S.Ct. 242, 62 L.Ed. 683(1918)).

The Supreme Court has also recognized that "there are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable." *Northern Pacific Ry. Co. v. United States,* 356 U.S. 1, 5, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958). In the instant action, Plaintiff does not contend that the Conditions of Reappointment fall within this category of *per se* illegal violations.

The final standard for analyzing Section 1 claims is to use a "quick look" rule of reason analysis. "The abbreviated rule of reason is an intermediate standard. It applies in cases where *per se* condemnation is inappropriate, but where 'no elaborate industry analysis is required to demonstrate the anticompetitive character' of an inherently

suspect restraint." *Brown Univ.*, 5 F.3d at 669 (citing *NCAA*, 468 U.S. at 109); *see also Nat'l Soc'y of Professional Engineers v. United States*, 435 U.S. 679, 692, 98 S.Ct. 1355, 55 L.Ed.2d 637 (1978) (hereinafter "Professional Engineers"); *IFD*, 476 U.S. at 459. Where the quick look analysis is used competitive harm is presumed, and the defendant is required to promulgate "'some competitive justification' for the restraint, 'even in the absence of detailed market analysis' indicating actual profit maximization or increased costs to the consumer resulting from the restraint." *Id.* (citing *NCAA*, 468 U.S. at 110.) However, in the absence of legitimate justifications, "the court condemns the practice without ado." *Id.* (citing *Chicago Prof'l Sports Ltd. P'ship v. Nat'l Basketball Ass'n*, 961 F.2d 667, 674 (7th Cir.1992), *cert. denied*, 506 U.S. 954, 113 S.Ct. 409, 121 L.Ed.2d 334 (1992)). Where procompetitive justifications are asserted by the defendant, then the court must engage in a complete rule of reason analysis, weighing the overall reasonableness of the restraint.

In the case *sub judice*, Plaintiffs analyze the Conditions of Reappointment under the quick look rule of reason analysis, arguing that the Conditions of Reappointment constitute a facially anticompetitive restraint. (Pl. Supp. Br. at 28.)[3] In response, Defendant contends that using a quick look analysis is inappropriate here because "[t]he quick look analysis does not apply, as a matter of law, to this challenged non-price vertical restraint. The 'horizontal competitor' quick look trilogy of cases [Dr. Gordon] cites are inapposite and [*California Dental Association v. FTC*,

[3] In the background section of their brief, Plaintiffs include, a section regarding the Hospital's market position. (Pl. Supp. Br. at 17.) However, nowhere in Plaintiffs argument section is this issue discussed.

526 U.S. 756, 119 S.Ct. 1604, 143 L.Ed.2d 935 (1999)] has all but eliminated quick look as a standard in professional 'information restraint' cases." (Def. Opp. Br. at 14.) Finally, in their reply brief, Plaintiffs assert that "[t]he Hospital's clean division between a 'quick look' analysis and a 'traditional rule of reason analysis [] is legally unfounded." (Pl. Reply Br. at 4.) Thus, as a threshold matter, the court must determine the proper framework for analyzing the Conditions of Reappointment.

The starting point for determining whether to apply the quick look analysis or a full rule of reason analysis is to characterize the agreement at issue, here the Conditions of Reappointment. Agreements between entities at the same market level are termed "horizontal market restraints," whereas those between entities at different market levels are referred to as "vertical market restraints." *See, e.g., IFD,* 476 U.S. at 459; *Univ. Oklahoma,* 468 U.S. at 99 (defining a horizontal restraint as "an agreement among competitors on the way in which they will compete with each other"); *Orson, Inc. v. Miramax Film Corp.,* 79 F.3d 1358, 1368 (3d Cir.1996) ("Agreements between entities at different market levels are termed 'vertical restraints.' ") In the instant action, the Conditions of Reappointment is a vertical agreement because the parties to the agreement are Dr. Gordon and the Hospital, entities at different market levels.[4] However, the parties

[4] At one point Plaintiffs imply that the restraint was horizontal by stating "[t]he information constraints in the [Conditions of Reappointment] were designed to, and in fact did, destroy horizontal competition between Dr. Gordon and Dr. Nancollas." (Pl. Reply Br. at 8.) However, the Supreme Court has stated that "a restraint is horizontal not because it has horizontal effects, but because it is the product of a horizontal agreement." *Business Electronics Corp. v. Sharp Electronics*

(Continued on following page)

disagree as to the effect of this fact on the court's analysis. Defendant's position is that the quick look analysis cannot be applied to a non-price vertical restraint. (Def. Opp. Br. at 4-5.) However, Plaintiffs aver that "[n]either the Supreme Court nor the federal appellate courts have limited as a matter of law abbreviated rule of reason analysis to horizontal restraints." (Pl. Reply Br. at 8.)

In *IFD,* a group of denitists [sic] entered into an agreement to refuse the submission of x-rays to dental insurers that the insurers sought to use in determining the payment of benefits. *IFD*, 476 U.S. at 448. The Supreme Court agreed with the Federal Trade Commission's finding that that the agreement constituted an unreasonable restraint on trade. *Id.* at 466. The Court first addressed the *kind* of agreement at issue, specifically, "a horizontal agreement among the participating dentists to withhold from their customers a particular service that they desire – the forwarding of x-rays to insurance companies." *Id.* at 459. The Court went on to state, "[w]hile this is not price fixing as such, no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement." *Id.* (citing *Professional Engineers,* 435 U.S. at 692.)

Defendant relies upon the Court's designation of the agreement in *IFD* as a horizontal restraint, as well as other cases in which courts applied a traditional rule of reason analysis to non-price vertical restraints, in support of its position that the quick look analysis only applies to cases involving horizontal agreements. *Orson,* 79 F.3d at

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Corp., 485 U.S. 717, 730, 108 S.Ct. 1515, 99 L.Ed.2d 808 (1988). Thus, the court proceeds based on the Conditions of Reappointment being characterized as a vertical agreement.

1368 ("The Supreme Court has instructed that vertical restraints of trade, which do not present an express or implied agreement to set resale prices, are evaluated under the rule of reason."); *MHB Distribs., Inc. v. Parker Hannifin Corp.*, 800 F.Supp. 1265, 1268 (E.D.Pa.1992) ("The appropriate standard for reviewing vertical non-price restraints is rule of reason."); *Parikh v. Franklin Med. Ctr.*, 940 F.Supp. 395, 401 (D.Mass.1996) ("Given the potential harms and benefits to competition flowing from vertical agreements . . . courts generally apply a rule of reason in deciding whether a particular agreement violates § 1 of the Sherman Act. . . .").

While Defendant has not cited any cases in which a court *limits* the abbreviated rule of reason analysis to horizontal price constraints, in each of the cases cited by Plaintiffs where the abbreviated rule of reason was used, the agreements at issue were horizontal. Moreover, he [sic] court here cannot conclude that the Conditions of Reappointment were so anticompetitive on their face that the abbreviated rule of reason analysis is appropriate. The Conditions of Reappointment in no way limited Dr. Gordon's ability to advertise his services, and he was provided with at least two avenues of communicating his concerns about Dr. Nancollas's procedure. (Def.Supp.Ex. 21.) Thus, the cases discussed above are not factually analogous. Accordingly, the court will analyze Count I of Plaintiffs' amended complaint using a full rule of reason analysis.

As the court will apply a full rule of reason analysis, the initial burden rests on Plaintiffs to show that the Conditions of Reappointment resulted in anti-competitive effects in the relevant product and geographic markets. *Brown Univ.*, 5 F.3d at 668. Plaintiffs may satisfy their

burden by presenting proof of the Hospital's market power. *Id.* (citing *Univ. Oklahoma,* 468 U.S. at 110). The parties agree that the relevant product market is facility services in outpatient cataract surgery. However, the parties do dispute whether Plaintiffs have established that the Hospital possessed market power in the relevant geographic market.

"[T]he relevant geographic market is the area in which a potential buyer may rationally look for the goods or services he or she seeks." *Eichorn v. AT & T Corp.,* No. 99-5791, 2001 WL 410084, -F.3d(3d Cir. April 23, 2001) (citing *Pennsylvania Dental Ass'n v. Med. Serv. Ass'n of Pennsylvania,* 745 F.2d 248, 260 (3d Cir.1984), *cert. denied,* 471 U.S. 1016, 105 S.Ct. 2021, 85 L.Ed.2d 303 (1985)); *see also Morgenstern v. Wilson,* 29 F.3d 1291, 1296 (8th Cir.1994) ("The geographic market encompasses the geographic area to which consumers can practicably turn for alternative sources of the product and in which antitrust defendants face competition."), *cert. denied,* 513 U.S. 1150, 115 S.Ct. 1100, 130 L.Ed.2d 1068 (1995). Defining a geographic market "cannot be performed with mathematical accuracy; it is simply the recognition of the field in which meaningful competition is said to exist." *Forsyth v. Humana, Inc.,* 114 F.3d 1467, 1475-76 (9th Cir.1997) (citing *United States v. Continental Can Co.,* 378 U.S. 441, 449, 84 S.Ct. 1738, 12 L.Ed.2d 953 (1964)), *aff'd,* 525 U.S. 299, 119 S.Ct. 710, 142 L.Ed.2d 753 (1999). The geographic market definition must instead "conform to commercial reality." *Id.* (citing *Brown Shoe Co. v. United States,* 370 U.S. 294, 336, 82 S.Ct. 1502, 8 L.Ed.2d 510 (1962)). Finally, "[t]he determination of a relevant geographic market is normally a question of fact for the jury." *Martin B. Glauser Dodge, Co. v. Chrysler Corp.,* 570 F.2d 72, 81 n. 18

(3d Cir.1977), *cert. denied,* 436 U.S. 913, 98 S.Ct. 2253, 56 L.Ed.2d 413 (1977).

The court here finds that there exists a material issue of fact as to the proper scope of the relevant geographic market inquiry that cannot be decided as a matter of law in the instant motion for summary judgment. Plaintiffs profer the report of their expert Dr. Martin Gaynor, a health economist expert who concluded that the relevant geographic market for the services offered by Dr. Gordon is Mifflin and Juniata Counties. (Def. Supp. Ex. 62, "Gaynor Rep." at ¶¶ 33, 40.) Dr. Gaynor analyzed the following in reaching his conclusions: (1) data regarding where patients have cataracts treated; (2) geographic characteristics of the area; (3) patient characteristics; (4) the cataract treatment process; (5) the Hospital's ability to offer Dr. Nancollas's procedure to consumers over an extended period of time while charging higher fees for services than areas like State College or Harrisburg; and (6) testimony from market participants. (Gaynor Rep. at 6-14; Gaynor Supp. Rep. at ¶¶ 77-80, 109-125.)

Defendant rejects Plaintiffs' definition of the relevant geographic market and asserts that "Dr. Gordon . . . has not defined a relevant geographic market for cataract surgery. He has, instead, defined the Hospital's primary service area, which is not, by any stretch of the imagination, a relevant geographic market." (Def. Br. Supp. Mot. Summ. Jud. at 33.) Defendant relies on *Miller v. Indiana Hospital,* 814 F.Supp. 1254, 1262 (W.D.Pa.1992), in support of its position that a service area does not necessarily equate to a relevant geographic market definition. (Def. Supp. Br. at 34.) In *Miller,* the court rejected the plaintiff's definition of relevant geographic area which was based on the area that the defendant hospital referred to as its

primary service area. 814 F.Supp. at 1262. Instead, the court held that the relevant geographic market must include "those hospitals which are perceived as attractive alternatives to [the defendant hospital] by physicians, third-party payors and 'above all by patients who 'vote with their feet' by leaving the county in large numbers when they require hospitalization.'" *Id.* (citing *Steuer National Med. Enters., Inc.*, 672 F.Supp. 1489, 1514 (D.S.C.1987), *aff'd* 846 F.2d 70 (4th Cir.1988)).

Based on *Miller,* the court agrees that if Dr. Gaynor's only basis for his definition of the relevant geographic market was the Hospital's primary service area, Plaintiffs would not have raised a material issue of fact as to relevant geographic market. However, Plaintiffs' expert went beyond this and based his conclusions upon other factors including the characteristics of many cataract patients,[5] the geography of Mifflin and Juniata Counties,[6] and patient flow data. Plaintiffs concede that in 1996, 22% of cataract patients in Mifflin and Juniata counties left the area for care. (Pl. Resp. Br. at 26.) However, Plaintiffs contend that "the fact that some patients leave the market does not prove that the geographic market is broader than Mifflin and Juniata counties." (*Id.* citing *Houser v. Fox Theater Mgt. Corp.*, 845 F.2d 1225, 1230 n. 10 (3d Cir.1988) ("[E]vidence that a minority of customers might travel . . . is not enough to support [defendant's] contention

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[5] Dr. Gaynor presents that cataract patients are usually elderly and therefore may not be able to provide their own transportation to and from medical appointments. (Gaynor Supp. Rep. at ¶ 118.)

[6] Dr. Gaynor notes that Mifflin and Juniata counties are separated from areas with more hospitals by mountain ranges, making travel more difficult. (Gaynor Supp. Rep. at ¶ 117.)

that the relevant geographic market should be expanded to include those cities as a matter of law.").)

Defendants attempt to rebut Plaintiffs' position by introducing evidence that Dr. Gordon and certain optometrists referred patients from Mifflin and Juniata counties to ophthalmologists outside the area for care. Dr. Gordon's testimony was that he referred patients outside the area for complex surgery that was not performed at Lewistown Hospital (Gordon Dep. at 382-85.) Such medical services are not the subject of the instant claims. Dr. Gordon would also send patients to ophthalmologists outside of Mifflin and Juniata counties if he could not fit into his schedule. (*Id.* at 273-77, 315-21.) While Defendant would have the court believe that there is an absence of factual basis for Dr. Gaynor's definition of the relevant geographic market, the court finds that Dr. Gaynor's conclusions are supported, and that the issue of fact as to the relevant geographic market cannot be decided upon a motion for summary judgment.[7]

As there is an issue of fact as to the threshold definition of relevant geographic market, the court cannot here determine whether Plaintiffs have established their initial burden of showing anticompetitive effects from the Conditions of Reappointment through establishing Defendant's

[7] It appears that if the relevant geographic market inquiry is limited to Mifflin and Juniata counties, then Defendant concedes that there is at least some evidence that the Hospital possesses market power in that area. (Def. Supp. Br. at 40) ("No evidence exists, in this record, that the Hospital possesses market power in an antitrust-relevant geographic market that extends beyond [Mifflin and Juniata] Counties.")

market power. Accordingly, the court will deny Plaintiffs' motion for summary judgment on Count I.

2. *First Affirmative Defense: HCQIA Immunity*

Plaintiffs also move for summary judgment on Defendant's First affirmative defense wherein Defendant contends that it is immune from monetary damages for the 1996 suspension and the 1997 revocation as these actions constituted "professional review actions" under the HCQIA. The HCQIA was promulgated by Congress "to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior." *Matthews v. Lancaster General Hosp.*, 87 F.3d 624, 632 (3d Cir.1996) (citing H.R.Rep. No. 903, 99th Cong., 2d Sess. 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6287, 6384, 6384.) Accordingly, the HCQIA provides limited immunity from lawsuits seeking money damages against participants in professional peer review actions. 42 U.S.C. §§ 11101(5), 11111(a).

HCQIA defines "professional review action" as:

> [A]n action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

42 U.S.C. § 11151(9). Specifically excluded from the definition of professional review action are actions taken against physicians for conduct that is "primarily based on

. . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.* at § 11151(9)(B).

Moreover, there are certain standards set forth in HCQIA that must be met before a participant in a professional review action is entitled to immunity from suit:

> [A] professional review action must be taken-
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a). Finally, "[a] professional review action shall be presumed to have met the preceding [sic] standards necessary for [immunity] unless the presumption is rebutted by the preponderance of the evidence." *Id.* The Third Circuit has stated that the presumption "means that the *plaintiff* bears the burden of proving that the peer review process was *not* reasonable." *Matthews,* 87 F.3d at 633 (emphasis in original) (citing *Bryan v. James E. Holmes Reg'l Med. Ctr.,* 33 F.3d 1318, 1333 (11th Cir.1994), *cert. denied,* 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995)).

Plaintiffs attack the applicability of HCQIA to the case *sub judice* on several bases. First, Plaintiffs argue that the Hospital's actions did not constitute "professional review actions" under HCQIA for the following reasons: (1) the solicitation exception to the definition of professional review actions applies here; (2) the expulsion did not relate to Dr. Gordon's competence or professional conduct; (3) the expulsion was not based on conduct that affects patient welfare; (4) the purposes of HCQIA would be violated by using it punitively for physicians that criticize incompetent competitors; and (5) Dr. Gordon's conduct did not adversely affect a patient of the Hospital. Plaintiffs also aver that even if the expulsion constitutes a professional review action, the Hospital is still entitled to immunity because the four standards outlined in § 11112(a) are not met in the instant action. Finally, Plaintiffs contend that HCQIA does not immunize the 1996 suspensions, and punishing Dr. Gordon's speech using the HCQIA would violate the First Amendment.[8] Recognizing that Plaintiffs bear the burden of showing that the Hospital's actions were unreasonable, the court will address Plaintiffs' arguments *seriatim*.

a. *Solicitation Exception to Professional Review Action*

Plaintiffs contend that the 1997 revocation did not fall within the purview of HCQIA's definition of professional review action. In order for immunity under the HCQIA to

[8] Plaintiffs provide no argument regarding their position that the First Amendment would be violated if HCQIA immunity applied here. Accordingly, the court does not address this argument in the instant memorandum.

attach, there must have been a professional review action. The HCQIA defines professional review action, in relevant part, as "an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, *which is based on the competence or professional conduct* of an individual physician." 42 U.S.C. § 11151(9). However, the HCQIA goes on to clarify that a professional review action "is not considered to be based on the competence or conduct of a physician if the action is primarily based on . . . (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.* at § 11151(9)(B). Plaintiffs argue that Dr. Gordon's act of sending a letter to the Hospital administration and calling Mrs. Seecora were intended to solicit or retain business. Defendant, in response, argues that Dr. Gordon has acknowledged that his purposes were other than to solicit or retain business.

The court here finds that there is a material issue of fact as to Dr. Gordon's intent in mailing the June 4, 1997 letter to the Hospital board and in calling Mrs. Seecora. As noted by Plaintiffs, Mrs. Seecora testified that she perceived Dr. Gordon's call to be an attempt to obtain her business if she had to have her second cataract removed. (Pl. Attachments to Mem. In Supp. Mot. Summ. Jud., "Pl. Supp. Ex.," Tab 32 "Seecora Dep." at 32, 39.) Defendant points to Dr. Gordon's letter to Dr. Everhart, the Chairperson of the Hospital's Credentials Committee during the relevant period, and his testimony before the Hearing Officer in his Fair Hearing and Appeals process. Dr. Gordon did respond in the negative to a question about whether he made Mrs. Seecora promise to see him instead of going back to Dr. Nancollas for a second cataract procedure. (Def. Opp.

Ex. J at 136-37.) However, based on this evidence, the court cannot determine as a matter of law whether Dr. Gordon's primary intent was to solicit or retain business. While immunity is an issue of law, the jury must make determinations of fact regarding the intent of an individual. Thus, as the intent of Dr. Gordon remains at issue, the court will allow the parties to present to the jury the question of Dr. Gordon's intent, and then the court will determine as a matter of law whether or not the Hospital is entitled to immunity under the HCQIA.

b. *Professional Review Action*

Plaintiffs make several other arguments why the Hospital's actions do not fall within the definition of professional review action, none of which are persuasive to the court. Plaintiffs assert that the expulsion of Dr. Gordon did not "relate to the competence or professional conduct of a physician" as required by 42 U.S.C. § 11151(9). The Hospital has nowhere asserted that Dr. Gordon was an incompetent physician.[9] However, the Hospital does aver that Dr. Gordon's actions were unprofessional. Essentially, Plaintiffs are arguing that the HCQIA will not immunize persons or bodies unless their professional review actions are based on a physician's professional competence. The Hospital has documented extensively Dr. Gordon's history of outbursts at Hospital staff, his condescending treatment of his own patients, and his harassment and intimidation of Dr. Nancollas's elderly patients. *See supra* section I.A. Such conduct is clearly

[9] In fact, Dr. Everhart stated at the August 22, 1997 hearing that "we all agreed that Dr. Gordon was an excellent surgeon." (Def. Stat. Mat. Facts at ¶ 118.)

unprofessional, and Plaintiffs' assertions to the contrary will not defeat the Hospital's position that its actions constituted professional review actions under the HCQIA.

Plaintiffs next argue that the Hospital's actions do not fall within HCQIA's definition of professional review action because it was not based on conduct that "affects or could affect adversely the health or welfare of a patient or patients." 42 U.S.C. § 11151(9). Plaintiffs assert that "the Hospital concedes that the expulsion was based entirely on Dr. Gordon's violation of" the Conditions of Reappointment. (Pl. Br. in Opp. Def. Mot. Summ. Jud. at 4.) However, what Plaintiffs neglect to note is that the purpose of the Conditions of Reappointment was to deter conduct that would adversely affect the health or welfare of patients, most notably harassing and intimidating telephone calls to elderly patients. The court is persuaded by the reasoning of other courts which found that unprofessional behavior on the part of physicians, regardless of its relationship to medical competence, falls within the purview of HCQIA's definition of professional review action.[10]

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[10] *See, e.g., Morgan v. PeaceHealth, Inc.*, 101 Wash.App. 750, 14 P.3d 773, 783 (Wash.App.2000) ("[U]nprofessional conduct may adversely affect the quality of health care. Even unprofessional conduct toward other staff members may detrimentally affect patient care."); *Doctor's Med. Clinic v. City of Jackson*, 569 N.W.2d 231, 233, 235 (Minn.Ct.App.1997) (holding that HCQIA immunity applied where "[t]he governing board found that . . . [the physician's] inability to work cooperatively with the other physicians threatened the hospital's ability to function effectively and resulted in a hospital environment not conducive to quality patient care," despite the fact that the physician's medical competence was not questioned) *aff'd in relevant part*, 581 N.W.2d 30 (Minn.1998); *Bryan v. James E. Holmes Med. Ctr.*, 33 F.3d 1318, 1326 (11th Cir.1994) (finding HCQIA immunity applied where physician "was the subject of more than fifty written incident reports

(Continued on following page)

Plaintiffs' next argument is that the purposes of HCQIA would be violated if it is found to apply here, namely to address "instances in which physicians injure patients through incompetent or unprofessional service," H.R.Rep. No. 99-903, 99th Cong., 2d Sess. (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384. However, as discussed *supra*, HCQIA does not contemplate only injuries to patients due to incompetent medical treatment. It also addresses "unprofessional" physician behavior that adversely affects quality health care, the exact situation that exists here. Accordingly, the court finds Plaintiffs' arguments on this issue unpersuasive.

Finally, Plaintiffs contend that Mrs. Seecora was not a patient of the Hospital and therefore the decision to revoke Dr. Gordon's clinical privileges does not constitute a professional review action. Again, the court rejects Plaintiffs' argument. Dr. Gordon was a member of the Hospital's medical staff when he made the phone call to Mrs. Seecora. Moreover, the cataract procedure that she had undergone, while several months prior, had taken place at the Hospital and was performed by Dr. Nancollas, another Hospital staff physician. Finally, Mrs. Seecora's daughter called and complained to the Hospital about the telephone call, indicating that she believed that the Hospital could

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involving unprofessional or disruptive behavior, usually complaints regarding . . . abusive treatment of nurses, technicians, and even fellow physicians," and "nurses in the intensive care unit at [the hospital] were refusing to care for [the physician's] patients on anything but a rotating basis for fear of becoming the object of his volcanic temper. For their part, surgical nurses complained that Bryan's verbal abuse compounded an already stressful environment, precluding them from operating at peak performance."), *cert. denied* 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995).

protect Mrs. Seecora. As Plaintiffs have offered no support for their contention that Mrs. Seecora was not a patient of the Hospital, the court finds no merit to Plaintiffs' argument that Defendant's HCQIA immunity defense should fail on this basis.

Upon consideration of the foregoing, the court finds that unless the solicitation exception contained in § 11151(9)(B) of HCQIA applies here, the Hospital's actions did constitute a professional review action, and it is entitled to immunity from monetary damages. However, there remain material issues of fact regarding Dr. Gordon's intent in sending [sic] June 4, 1997 to the Hospital Board and administration and contacting Mrs. Seecora. Accordingly, the court cannot here say as a matter of law that immunity applies. However, the issue of Dr. Gordon's intent will be submitted to a jury, and then the court will decide as a matter of law whether immunity applies.

c. *§ 11112 Standards for HCQIA Immunity*

Plaintiffs proffer an alternative argument for why Defendant is not entitled to HCQIA immunity even if the revocation is found to be a professional review action. In order for HCQIA immunity to be invoked, the professional review action must be taken: (1) with reasonable belief that it was in furtherance of quality health care; (2) following a reasonable effort to obtain facts; (3) following adequate notice and hearing procedures; and (4) with a reasonable belief that the action was warranted by the known facts. 42 U.S.C. § 11112(a). A professional review action is presumed to be reasonable, and it is Plaintiffs' burden to show by a preponderance of the evidence that it did not meet the standards of § 11112(a). *Id.; Matthews,* 87

F.3d at 633. The court here finds that Plaintiffs have not met their burden of showing that the standards contained in § 11112(a) have been met or even that there exists an issue of material fact for the jury.

The court need not address at length whether the 1996 suspension and the 1997 revocation actions were taken upon reasonable belief that they were in furtherance of quality health care. As discussed *supra,* other courts have found that even where technical competence is not at issue, a physician's ability to work well with other staff members and not be disruptive is linked to quality health care. The Hospital has presented the court with a history of documentation for a period of more than ten years that shows the Hospital's attempts to address these exact behaviors by Dr. Gordon. Plaintiffs have not rebutted the voluminous evidence presented by Defendant that it believed the 1996 suspension and the 1997 revocation were in furtherance of quality health care.

Similarly, Dr. Gordon has not raised a triable issue of fact with respect to whether the Hospital used reasonable efforts to obtain the facts of the matter and provided him with notice and hearing, the second and third requirements for HCQIA immunity. Before the 1996 suspension, a Hearing Officer conducted a hearing for over three days where twenty witnesses testified. With regard to the 1997 revocation, Dr. Gordon was invited, with his attorney, to meet with Dr. Everhart and two other physicians in order to discuss the mass mailing and the telephone contact with Mrs. Seecora. Dr. Gordon also received a hearing prior to the revocation and appealed the decision of the Hearing Officer. Accordingly, the court is satisfied that the Hospital undertook reasonable efforts to obtain the facts of

the matter and provided Dr. Gordon notice of its intended action and ample opportunity for a hearing.

Finally, the court finds that the Hospital had a reasonable belief that the actions were warranted by the facts. The Hospital had tried over a period of many years to control Dr. Gordon's disruptive and unprofessional behavior. However, at every turn Dr. Gordon violated the restrictions placed on him by the Hospital. Thus, the Hospital possessed a reasonable belief that its actions were warranted by the facts.

As the court has determined that there is an issue of fact as to Dr. Gordon's primary intent in circulating the letter of complaint and contacting Mrs. Seecora, the court will deny Plaintiffs' motion for summary judgment on Defendant's first affirmative defense. However, as the court has determined as a matter of law that all of the requirements of 42 U.S.C. § 11112(a) have been met by the Hospital, the only issue for the jury is whether Dr. Gordon's primary purpose was to solicit or retain business. If the jury determines that this was his primary purpose, then HCQIA immunity is inappropriate in the instant action. However, if the jury determines that his primary purpose was other than to solicit or retain business, then HCQIA would immunize the Hospital from monetary damages for its actions.

3. *Fourteenth Affirmative Defense*

While Plaintiffs purport to move for summary judgment on Defendant's fourteenth affirmative defense that Plaintiffs claims are frivolous or in bad faith, Plaintiffs offer no argument in their briefing why summary judgment is appropriate on this affirmative defense. Accordingly, in

the absence of any legal or factual support for their motion, the court will deny Plaintiffs' motion for summary judgment on Defendant's fourteenth affirmative defense.

B. *Defendant's Motion*

Defendant moves for summary judgment on all of Plaintiffs' claims on a number of theories. The court will address these in turn.

1. *Existence of a Conspiracy Between Defendant and Geisinger and/or Robert Postal*

Defendant seeks summary judgment on Counts I, IV, V, VI, VII, and VIII arguing that there is no genuine issue of material fact that the Hospital conspired with Geisinger and/or Robert Postal. Counts I, IV, V, and VI are all brought pursuant to Section 1 of the Sherman Act. Any claim under Section 1 of the Sherman Act requires that there exists a concerted action or a conspiracy. *Siegel Transfer, Inc. v. Carrier Express, Inc.*, 54 F.3d 1125, 1131 (3d Cir.1995); *Big Apple BMW, Inc. v. BMW of North Am., Inc.*, 974 F.2d 1358, 1364 (3d Cir.1992), *cert. denied*, 507 U.S. 912, 113 S.Ct. 1262, 122 L.Ed.2d 659 (1993) (hereinafter "BMW"). Counts VII and VIII are conspiracy to monopolize claims which require that there be evidence of a conspiracy in order to survive a motion for summary judgment.

Regardless of motivation, unilateral action will not result in liability under Section 1. *Siegel Transfer*, 54 F.3d at 1131. Instead, there must be a "unity of purpose or a common design and understanding or a meeting of the minds in an unlawful arrangement." *Id.* (quoting *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 771,

104 S.Ct. 2731, 81 L.Ed.2d 628 (1984)). "Proof of concerted action requires evidence that two or more distinct entities agreed to take action against a plaintiff." *Id.* (citing *Weiss v. York Hosp.*, 745 F.2d 786, 813 (3d Cir.1984)). The plaintiff in a Section 1 case must show a causal relationship between pressure from one conspirator and an anticompetitive decision of another conspirator. *See BMW*, 974 F.2d at 1364.

In *Petruzzi's IGA v. Darling-Delaware Co.*, 998 F.2d 1224 (3d Cir.1993), *cert. denied*, 510 U.S. 994, 114 S.Ct. 554, 126 L.Ed.2d 455 (1993), the Third Circuit discussed the level of proof of concerted activity necessary at the summary judgment stage of an antitrust case. *Id.* at 1230. The court there noted that a nonmovant plaintiff in a Section 1 antitrust claim may "rely solely on circumstantial evidence and the reasonable inferences drawn from such evidence" to show concerted activity, and that where the nonmovant has offered such circumstantial evidence, "the movant defendant bears the burden of proving that drawing an inference of unlawful behavior is unreasonable." *Id.* (citing *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 112 S.Ct. 2072, 119 L.Ed.2d 265 (1992)). Relying upon the Supreme Court's decision in *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986), the court in *IGA* noted that "evidence which is equally consistent with legal and illegal conduct, standing alone, cannot support an inference of antitrust conspiracy." *IGA*, 998 F.2d at 1230 (citing *Matsushita*, 475 U.S. at 588).

Simply offering *any* economic basis for a decision is insufficient for a defendant to succeed on a motion for summary judgment. Instead, "the focus must remain on the evidence proffered by the plaintiff and whether that

evidence 'tends to exclude the possibility that [the defendants] were acting independently.'" *Id* . at 1231 (citing *Monsanto v. Spray-Rite Serv. Corp.*, 465 U.S. 752, 764, 104 S.Ct. 1464, 79 L.Ed.2d 775 (1984)). Pared down, in addressing a motion for summary judgment where there is circumstantial evidence of conspiracy, courts must recognize that "the acceptable inferences which can be drawn from circumstantial evidence vary with the plausibility of the plaintiffs' theory and the dangers associated with such inferences." *Id.* Proof of causation, a requirement discussed *supra*, cannot be established simply by showing that there was a series of complaints from one alleged conspirator followed by an anticompetitive decision by the other alleged conspirator. *BMW*, 974 F.2d at 1364. "A jury may not be permitted to speculate as to cause from a chain of events." *Id.*

In the instant action, the Hospital contends that Plaintiffs have not proffered any evidence, direct or circumstantial, that the Hospital conspired with either Geisinger or Robert Postal to suspend Dr. Gordon in 1996 and revoke his staff privileges in 1997. However, Plaintiffs contend that "there is ample evidence that Geisinger pressured the Hospital to muzzle Dr. Gordon's criticism of its employee, that the Hospital had no independent reason to impose such a blatant gag on truthful speech, and did so at the insistence of its biggest contract party." (Pl. Resp. Br. at 38.)

Plaintiffs present the following evidence in support of their position that a reasonable factfinder could infer that the Hospital conspired with Mr. Postal and/or Geisinger: In 1989 the Hospital refused to discipline Dr. Gordon for comments that were allegedly made about Dr. Nancollas to a nursing home patient. (Exs. to Pl. Resp. to Def. Mot. for

Summ. Jud. ("Pl.Resp.Ex."), Tab 31.) Furthermore, the medical director of Geisinger, Dr. Ayoub, shared with administrators at the Hospital his concerns over Dr. Gordon's contacting patients and criticizing Dr. Nancollas.[11] Plaintiffs describe these decisions on the part of the Hospital as "early reluctance" to discipline Dr. Gordon. They contend that this "early reluctance" was also exhibited when Dr. Gordon was not disciplined for criticizing Dr. Nancollas during a surgical department meeting. (Pl. Resp. Br. at 41.) Plaintiffs believe that after 1994, "the Hospital made an abrupt 180-degree change in its policy toward Dr. Gordon's calls to patients at their homes." (*Id* . at 42.)

Plaintiffs attempt to explain this change by looking at the relationship between the Hospital and Geisinger. Plaintiffs note that Geisinger rents facility services and office space from the Hospital and that the Hospital was dependant upon Geisinger for rents for space in a Medical Office Building owned by the Hospital. In 1991 Geisinger was renting two-thirds of the office space in the Medical Office Building, and Geisinger could terminate its sublease by giving appropriate notice either in 1992, 1997, or 2002. Plaintiffs' literal "conspiracy theory" is partially

[11] Plaintiffs also cite to an evaluation apparently written by Dr. Nancollas that states that the Hospital should realize with regard to Dr. Gordon that "a lack of action could have serious implications." (Pl. Resp. Ex. 28, at 3 ¶ 6.) However, Plaintiffs have taken this paragraph out of context and supplied inferences not contained therein. The paragraph that ended with this statement describes concerns over Dr. Gordon obtaining illegal access to patient files "as well as alleged interference with a patient . . . while a patient at Lewistown Hospital." This paragraph makes no reference indicating that the "serious implications" suggested by Plaintiffs, i.e. illegal gag restraints on Dr. Gordon's patient contacts, were contemplated by Dr. Nancollas.

premised on its characterization of these facts: "[A]s Geisinger was increasing its pressure to gag Dr. Gordon, the Hospital realized that Geisinger could terminate the Sublease within the next year to devastating effect for the Hospital." (*Id.* at 44.)

Plaintiffs note that the Hospital was simultaneously dealing with complaints about Dr. Gordon and looking for ways to improve its relationship with Geisinger. Plaintiffs assert that the 1996 suspension was a divergence from the Hospital's previous policy of ignoring complaints about Dr. Gordon contacting patients. Plaintiffs state "the Hospital not only changed its policy, but applied the new policy retroactively" because it had not previously disciplined Dr. Gordon for telephone contacts to patients. (*Id.* at 45.) Plaintiffs contend that the Hospital was unconcerned with the truth or importance of the communications between Dr. Gordon and patients that he contacted. Plaintiffs tie all of these events together by stating that "[u]ltimately, the Hospital required Dr. Gordon to sign the [Conditions of Reappointment] less than six months before Geisinger's April 30, 1997 deadline for opting out of the renewal of the sublease. In other words, after years of pressure, Geisinger was able to use its financial pressure to force the Hospital to curtail Dr. Gordon's ability to compete." (*Id.* at 46.)

Plaintiffs aver that these facts are entitled to the broadest inferences available and that Defendant is not entitled to summary judgment based on lack of evidence of a conspiracy between the Hospital and Geisinger and/or Mr. Postal. The court is unpersuaded by Plaintiffs' argument. Plaintiffs rely heavily on their interpretation of the Hospital's discipline of Dr. Gordon as a "180 degree change" in its policies toward Dr. Gordon, and citing *Big Apple BMW, Inc. v. BMW of North Am., Inc.*, 974 F.2d 1358

(3d Cir.1992), and *Arnold Poniac* [sic] *-GMC, Inc. v. Budd Baer, Inc.*, 826 F.2d 1335 (3d Cir.1987), contend that the Third Circuit allows for an inference of conspiracy where an antitrust defendant reverses its position with respect to a plaintiff upon receiving complaints from the plaintiff's competitor.

Plaintiffs must establish a causal connection between any alleged pressure from Geisinger and the 1996 suspension and the 1997 revocation. *BMW*, 974 F.2d at 1364. The reversal of position in *BMW* involved plaintiffs that sought to obtain BMW automobile franchises in various locations. When one of the plaintiffs first met with a representative from BMW, that representative was "favorably impressed" with the plaintiff as an individual. *Id.* at 1365. Furthermore, the court noted that the independent reasons proffered by the defendants for the denial of the franchise "when contrasted to [the defendant's] earlier actions expressive of an interest in [the plaintiffs]" created an issue of fact for the jury as to whether it was reasonable to infer a conspiracy between the distributor and its dealership body. Evidence of a change in the defendant's position was not the sole basis for the court's decision in *BMW*. There was also a plethora of evidence that the distributor's proffered reason for denying the franchise was pretextual. *Id.* at 1374-80 ("The [plaintiffs] have countered each alleged reason [for the defendant's decision] with evidence that both discredits [the defendant's] witnesses and provides independent support for [the plaintiffs'] claim that [the defendant] and its dealers acted in concert to repeal any . . . competition.") *Budd Baer* also involved a plaintiff seeking an automobile franchise. There, however, the change in position was well-established where the distributor "had taken several steps toward granting

[plaintiff] a Buick franchise" prior to meeting with a competitor of the plaintiff. *Budd Baer,* 826 F.2d at 1338. It was only after that meeting that the defendant denied the franchise application. *Id.*

The case *sub judice* is different from the situation in both *BMW* and *Budd Baer.* Dr. Gordon was disciplined as early as 1985 when the Hospital placed Dr. Gordon on probation based on its findings that he had engaged in various acts of misconduct, including repeated contacts with a patient that made the patient feel harassed. *See supra* section I.A. These contacts included commentary on other physicians. Thus, the 45 day suspension in 1996 was not the first time that Dr. Gordon was disciplined for contacting patients of another physician. Following Dr. Gordon's Fair Hearing on the 1996 suspension, the Hearing Officer repeatedly stated in her opinion that the problem is the *manner* in which Dr. Gordon was expressing his concerns about Geisinger and Dr. Nancollas. (Def.Supp.Ex. 16.) Furthermore, Dr. Gordon relies on the fact that the Hospital did not discipline him for statements made about Dr. Nancollas at a surgical staff meeting. However, that situation was distinct from situations where comments were made in front of patients in harassing manners. (Pl.Resp.Ex. 226.) Thus, while the Hospital's discipline of Dr. Gordon became increasingly severe, Dr. Gordon had been the subject of various disciplinary actions for years. This is not like *Budd Baer* where there was a total reversal of position. Furthermore, Dr. Gordon has not pointed to any evidence similar to the rebuttal evidence presented by the plaintiffs in *BMW* that indicates that the Hospital's proffered reasons for their action, e.g. a long history of problems with Dr. Gordon's conduct, was pretextual. Finally, the 1996 suspension was based on

more than just Dr. Gordon's criticisms of Dr. Nancollas. In addition to inappropriate contacts with Dr. Nancollas's patients, the Hearing Officer also found that Dr. Gordon's confrontation with Dr. Querashi and his outburst and profanity directed at a nurse made the suspension an appropriate disciplinary action. *See supra* section I.A.

The court holds that Plaintiffs have failed to present evidence, direct or circumstantial, from which a reasonable jury could find that there existed a conspiracy between the Hospital and Geisinger and/or Mr. Postal. Therefore, Defendant is entitled to summary judgment on Counts I, IV, V, VI, VII, and VIII. The only claims that remain are Counts II and II [sic]. Therefore, Defendant's remaining arguments in support of summary judgment will only be addressed as they apply to these claims.

2. *HCQIA Immunity*

As discussed at length above, there remains an issue of fact as to whether the solicitation exception to HCQIA's definition of professional review action applies in the instant action. *See supra* section III.A.2. Accordingly, the court will deny Defendant's motion for summary judgment based on HCQIA immunity as it applies to Counts II and III.

3. *Claim for Injunctive Relief*

Defendant also presents two arguments why Plaintiffs are not entitled to injunctive relief. First, Defendant contends that Plaintiffs have waived their request for equitable relief based on a theory of "active pursuit." Second, Defendant argues that because the underlying

antitrust claims are meritless, the prayer for injunctive relief must be abandoned.

Defendant bases its active pursuit theory on Fourth and Eight Circuit case law where those courts held that physicians had abandoned their claims for injunctive relief where, in trial court, they failed to move for injunctive relief and did not "press the issue" of an injunctive remedy after the defendants asserted HCQIA immunity as an affirmative defense. (Def. Supp. Br. at 26 (citing *Imperial v. Suburban Hosp. Ass'n,* 37 F.3d 1026, 1031 (4th Cir.1994); *Sugarbaker v. SSM Healthcare,* 190 F.3d 905, 918 (8th Cir.1999), *cert. denied,* 528 U.S. 1137, 120 S.Ct. 980, 145 L.Ed.2d 931 (2000).). Defendant contends that "Dr. Gordon merely 'prayed' for an injunction.... Dr. Gordon does not point to the record where he either moved for injunctive relief or pressed the issue of injunctive relief when 'the vitality of the Complaint, in its entirety, was put to the test on an immunity defense.'" (*Id.*) Furthermore, Defendant contends that Plaintiffs have not demonstrated a continuing interest in obtaining an injunction against the Hospital.

The court rejects the Hospital's argument. The procedural postures of *Sugarbaker* and *Imperial* are different from what is present in the instant action. In both of those cases, the courts had dismissed claims on HCQIA immunity grounds, and the plaintiffs had never expressed a desire to maintain their claims for injunctive relief when the immunity defense was raised. *Sugarbaker,* 190 F.3d at 918; *Imperial,* 37 F.3d at 1031. In those cases the plaintiffs had failed to address the propriety of injunctive relief in response to the defendants' motions for summary judgment. Here, Plaintiffs are addressing the issue in response to the Hospital's motion for summary judgment and

maintain that injunctive relief falls outside HCQIA's purview. (Pl. Resp. Br. at 17.) Accordingly, the court will deny Defendant's motion for summary judgment on any claims for injunctive relief that arise under Counts II and III.

As to Defendant's assertion that Plaintiff is not entitled to injunctive relief because the underlying claims have no merit, the court has already granted summary judgment on Counts I, IV, V, VI, VII, and VIII. Accordingly, no injunctive relief sought under those claims will be granted. As discussed further *infra,* however, the court has not here determined that Counts II and III are without merit, and the court will deny Defendant's motion for summary judgment both as to the propriety of monetary damages and injunctive relief on Counts II and III.

4. *Count II – Illegal Tying Claim*

Plaintiffs allege in Count II that Defendant tied its facility services to the purchase of Geisinger ophthalmologic services (Amend. Compl. at ¶¶ 53-55.) Defendant contends, relying upon *Venzie Corp. v. United States Mineral Prods.,* 521 F.2d 1309 (3d Cir.1975), that the seller of a tying service must possess an economic interest in the market for the tied services. Defendant, however, asserts that the Hospital did not receive a direct economic benefit from the ophthalmologic surgeries performed by Dr. Nancollas, the Geisinger employed physician. Plaintiffs argue that no economic interest is necessary to establish an illegal tying arrangement. In the alternative, Plaintiffs aver that even if an economic interest is a prerequisite for an illegal tying claim, the court here "should recognize as sufficient those interests which motivate the hospital to

impair competition in the tied market since that is the inquiry that is the chief concern of anti-tying law." (Pl. Resp. Br. at 57.)

"Tying is defined as selling one good (the tying product) on the condition that the buyer also purchase another, separate good (the tied product)." *Town Sound & Custom Tops, Inc. v. Chrysler Motors Crop.*, 959 F.2d 468, 475 (3d Cir.1992), *cert. denied*, 506 U.S. 868, 113 S.Ct. 196, 121 L.Ed.2d 139 (1992). Some types of tying arrangements present a risk of stifling competition that the Supreme Court has deemed to be unacceptable, and therefore unreasonable *per se*. *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 9, 104 S.Ct. 1551, 80 L.Ed.2d 2 (1984). However, not every refusal to sell two products separately unreasonably restrains competition. *Id.* at 11. "[T]he essential characteristic of an invalid tying arrangement lies in the seller's exploitation of its control over the tying product to force the buyer into the purchase of a tied product that the buyer either did not want at all, or might have preferred to purchase elsewhere on different terms." *Id.* Thus, the Supreme Court condemns tying arrangements where a seller has market power that enables it to force the purchaser into a transaction that would not occur in a competitive market. *Id.* at 13-14. *Per se* condemnation of a tying arrangement is focused on the probability of anticompetitive consequences. *Id.* at 15-16. A "substantial volume of commerce" must be foreclosed by a tying arrangement in order for it to be condemned. *Id.*

One situation in which a tied product will be deemed illegal is where "the existence of market power is probable." *Id.* at 17. "When, however, the seller does not have either the degree or kind of market power that enables him to force customers to purchase a second, unwanted

product in order to obtain the tying product, an antitrust violation can be established only by evidence of an unreasonable restraint on competition in the relevant market." *Id.* at 17-18. The Court's inquiry in *Jefferson Parish* was (1) whether the defendant hospital was selling two products that could be tied together, and (2) if so, whether market power was used to force patients to accept the tying arrangement.

In the instant action, Defendant does not dispute the existence of two distinct product markets – hospital outpatient facility services and ophthalmologic services. Instead, the parties disagree as to whether the seller of a tying service must have an economic interest in the tied services. Plaintiffs provide ample case law in support of its position that an economic interest is not an element of an illegal tying claim. Specifically, Plaintiffs note that in *Jefferson Parish,* the Supreme Court did not impose a requirement of an economic interest in the tied product. In fact, the district court in that case had found that the defendant hospital's fees for the tied services were reasonably related to the services and materials provided by the Hospital. *Hyde v. Jefferson Parish Hosp. Dist. No. 2,* 513 F.Supp. 532, 539 (E.D.La.1981). Furthermore, the Third Circuit since *Jefferson Parish* has not required an economic interest in the tied product.[12] Defendant has offered no case law or argument to rebut Plaintiffs' position. Therefore, the court will not grant summary judgment in

[12] In outlining the test for an illegal tying claim in *Town Sound,* the Third Circuit cited the following elements: (1) a defendant seller ties two distinct products; (2) the seller possesses market power in the tying product market; and (3) a substantial amount of interstate commerce is affected. 959 F.2d at 477.

favor of the Hospital on Count II based on the economic interest argument.

5. *Relevant Geographic Market / Market Power*

Another argument presented by Defendant in support of its motion for summary judgment is that Defendant did not possess market power within the relevant geographic market. This argument is applicable to Plaintiffs' illegal tying claim, Count II of the amended complaint. In order to be deemed a *per se* violation of antitrust laws, a seller of the tying product must possess sufficient market power in the relevant geographic market. *Town Sound,* 959 F.2d at 477. Here, the Hospital avers that it did not possess market power in the cataract surgery market. However, the Hospital's argument is premised on the assumption that the relevant geographic market includes State College, Lewisburg, and Harrisburg, Pennsylvania. (Def. Supp. Br. at 32-39.) The court has already determined that there exists an issue of fact regarding the definition of the relevant geographic market. Thus, the court cannot say at this juncture of the proceedings as a matter of law that Defendant did not possess sufficient market power to violate the Sherman Act through an illegal tying arrangement.

6. *Harm to Competition*

The Hospital also argues that Plaintiffs have not established that the 1996 suspension and the 1997 revocation harmed competition in the cataract surgical services market. The purpose of antitrust laws is to protect competition and not competitors, therefore antitrust plaintiffs must show some harm to the competitive landscape from a

defendant's alleged anticompetitive acts. *See Tunis Bros. Co. v. Ford Motor Co.*, 952 F.2d 715, 728 (3d Cir.1992) (citing *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488, 97 S.Ct. 690, 50 L.Ed.2d 701 (1977)), *cert. denied*, 505 U.S. 1221 (1992). Here, the only remaining claims are Counts II and III – Plaintiffs' tying claim and Plaintiffs' monopolization claim.

Plaintiffs first argue with respect to their tying claim that they do not need to elaborate upon harm to competition. (Pl. Resp. Br. at 61 (citing *F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 106 S.Ct. 2009, 90 L.Ed.2d 445 (1986)).) In fact, the Supreme Court has stated that "there are certain agreements or practices which because of their pernicious effect on competition and lack of any redeeming virtue are conclusively presumed to be unreasonable and therefore illegal without elaborate inquiry as to the precise harm they have caused." *Northern Pacific Ry. Co. v. United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958). "Tying arrangements . . . may fall in that category, though not necessarily so." *White Motor Co. v. United States*, 372 U.S. 253, 262, 83 S.Ct. 696, 9 L.Ed.2d 738 (1963). The relevant inquiry is whether or not the seller of the tying product exercises sufficient economic power over the tying product to restrain free competition for the tied product. *Id.; see also Jefferson Parish*, 466 U.S. at 21 n. 31 ("The common core of the adjudicated unlawful tying arrangements is the forced purchase of a second distinct commodity with the desired purchase of a dominant 'tying' product, resulting in economic harm to competition in the 'tied' market.") (citing *Times-Picayune Publ'g Co. v. United States*, 345 U.S. 594, 613-14, 73 S.Ct. 872, 97 L.Ed. 1277 (1953)).

Here the court is not able to determine as a matter of law the amount of market power that Defendant exercises over the tying product, hospital outpatient facility services, because there remains a genuine issue of fact regarding the relevant geographic market. *See supra* section III.A.1. Therefore the court will not grant Defendant's motion for summary judgment on Count II of Plaintiffs' claim based on its argument that Plaintiffs have not presented ample evidence of harm to competition.

Turning to Count III, attempted monopolization, Plaintiffs argue first that consumer injury is presumed given the Hospital's market power. (Pl. Resp. Br. at 61.) Again, market power cannot be determined at this stage of the proceedings, and Defendant's motion for summary judgment will be denied as to Count III on this argument.

7. *Count III*

The court will now address Defendant's argument as to why Plaintiffs' attempted monopolization claim should fail. In Count III, Defendant is alleged to have attempted to monopolize the market for outpatient facility services. (Amend. Compl. at ¶ 59.) A claim for attempted monopolization requires a showing that the defendant (1) had specific intent to monopolize the relevant market, (2) engaged in anti-competitive or exclusionary conduct, and (3) possessed sufficient market power to come dangerously close to success. *Barr Laboratories, Inc. v. Abbott Laboratories,* 978 F.2d 98, 111 (3d Cir.1992) (gathering cases). Defendant argues that there is no "dangerous probability" that the Hospital will succeed at monopolizing the outpatient facility services market. (Def. Supp. Br. at 44.) It is impossible for the court to evaluate Defendant's chances of

monopolization where the relevant geographic market remains at issue. Accordingly, the court will deny Defendant's motion for summary judgment on Count III.

IV. *Conclusion*

The court will deny Plaintiffs' motion for summary judgment on Count I of the amended complaint as well as on Defendant's first and fourteenth affirmative defenses. Applying a traditional rule of reason analysis to Count I, Plaintiff bears the initial burden of showing anti-competitive effects on the relevant product and geographic markets. There remains an issue of fact as to relevant geographic market for out-patient facility services. Therefore, Plaintiffs have failed to meet their initial burden and are not entitled to summary judgment on Count I. There also remains an issue of fact as to whether the solicitation exception to HCQIA's definition of "professional review action" is applicable here, as the intent of Dr. Gordon is an issue of fact for the jury. Accordingly, the court will deny Plaintiff's motion for summary judgment on Defendant's first affirmative defense. Finally, Plaintiffs have offered no factual or legal arguments why the court should grant them summary judgment on Defendant's fourteenth affirmative defense, and thus the motion will be denied.

Plaintiffs have failed to point to any evidence that supports their allegations of a conspiracy between the Hospital and Geisinger and/or Mr. Postal. As conspiracy is an element of claims brought pursuant to Section 1 of the Sherman Act, as well as Plaintiffs' claim of conspiracy to monopolize, the court will grant Defendant's motion for summary judgment on Counts I, IV, V, VI, VII, and VIII of Plaintiffs' amended complaint. As there remains an issue

of material fact as to the relevant geographic market in the instant action, none of Defendant's bases for its motion for summary judgment on Counts II and III can be determined as a matter of law. Accordingly, the court will deny Defendant's motion for summary judgment on Counts II and III.

ORDER

In accordance with the foregoing memorandum of law, IT IS HEREBY ORDERED THAT:

(1) Plaintiffs' motion for summary judgment on Count I and on the first and fourteenth affirmative defenses of Defendant is DENIED.

(2) Defendant's motion for summary judgment on Counts, I, IV, V, VI, VII, and VIII of the amended complaint is GRANTED.

(3) Defendant's motion for summary judgment on Counts II and III of the amended complaint is DENIED.

(4) The clerk of court shall defer entry of judgment until the conclusion of the case.

APPENDIX

1996 OUTPATIENT CATARACT SURGERY PATIENT MIGRATION DATA SORTED ACCORDING TO IMPORTANCE TO THE HOSPITAL

A	B	C	D	E	F	G
17044	241	210	87.1%	33.9%	33.9%	87.1%
17084	41	37	90.2%	6.0%	39.9%	87.6%
17004	41	32	78.0%	5.2%	45.1%	86.4%
17059	44	32	72.7%	5.2%	50.2%	84.7%
17063	32	29	90.6%	4.7%	54.9%	85.2%
17066	55	26	47.3%	4.2%	59.1%	80.6%
17841	39	25	64.1%	4.0%	63.2%	79.3%
17051	28	22	78.6%	3.5%	66.7%	79.3%
17082	26	18	69.2%	2.9%	69.6%	78.8%
16652	120	17	14.2%	2.8%	72.4%	67.2%
17094	20	15	75.0%	2.4%	74.8%	67.4%
17099	14	14	100.0%	2.3%	77.0%	68.0%
17009	13	11	84.6%	1.8%	78.8%	68.3%
16823	193	11	5.7%	1.8%	80.6%	55.0%
17021	14	8	57.1%	1.3%	81.9%	55.1%
17058	7	7	100.0%	1.1%	83.0%	55.4%
17049	12	7	58.3%	1.1%	84.2%	55.4%
17243	23	7	30.4%	1.1%	85.3%	54.8%
17029	6	5	83.3%	.8%	86.1%	55.0%
17264	17	5	29.4%	.8%	86.9%	54.6%
17086	19	5	26.3%	.8%	87.7%	54.2%
17054	4	4	100.3%	.6%	88.4%	54.2%
17035	5	4	80.0%	.6%	89.0%	54.3%
16853	23	4	17.4%	.6%	89.7%	53.5%
16827	24	4	16.6%	.6%	90.3%	52.7%
17842	86	4	4.7%	.6%	90.9%	49.1%

KEY

A = ZIP CODE

B = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD OUTPATIENT CATARACT SURGERY IN 1996

C = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD OUTPATIENT CATARACT SURGERY AT THE HOSPITAL IN 1996

D = HOSPITAL'S SHARE OF ZIP CODE

E = ZIP CODE'S INDIVIDUAL CONTRIBUTION TO TOTAL NUMBER OF OUTPATIENT CATARACT SURGERIES PERFORMED AT THE HOSPITAL IN 1996

F = CUMULATIVE ZIP CODES' CONTRIBUTION TO TOTAL NUMBER OF OUTPATIENT CATARACT SURGERIES PERFORMED AT HOSPITAL IN 1996 ("LIFO")

G = THE HOSPITAL'S SHARE OF THE AGGREGATE ZIP CODES ("LOFI")

EXHIBIT B

1996 OUTPATIENT CATARACT SURGERY PATIENT MIGRATION DATA ASSUMING THAT 61 PROCEDURES WERE PERFORMED AT FREE-STANDING SURGERY CENTERS

A	B	C	D	E	F	G
*	61	61	0.0%	0.0%	0.0%	0.0%
17099	14	14	100.0%	2.6%	2.6%	18.7%
17058	7	7	100.0%	1.1%	3.4%	25.6%
17054	4	4	100.0%	.6%	4.0%	29.1%
17002	2	2	100.0%	.3%	4.4%	30.7%
17056	2	2	100.0%	.3%	4.7%	32.2%
17063	32	29	90.6%	4.7%	9.4%	47.5%
17084	41	37	90.2%	6.0%	15.3%	58.3%
17044	241	210	87.1%	33.9%	49.3%	75.5%
17009	13	11	84.6%	1.8%	51.0%	75.7%
17029	5	6	83.3%	.8%	51.8%	75.9%
17035	4	5	80.0%	.6%	52.5%	75.9%
17051	28	22	78.6%	3.6%	56.1%	76.1%
17004	41	32	78.5%	5.2%	61.2%	76.3%
17094	20	15	75.0%	2.4%	63.7%	76.2%
17059	44	32	72.7%	5.2%	68.8%	75.9%
17082	26	18	69.2%	2.9%	71.7%	75.6%
17841	39	25	64.1%	4.0%	75.8%	74.9%
17049	12	7	58.3%	1.1%	76.9%	74.6%
17021	14	8	57.1%	1.3%	78.2%	74.2%
17076	2	1	50.0%	.2%	78.4%	74.2%
17066	55	26	47.3%	4.2%	82.6%	72.1%
17052	15	7	46.7%	1.1%	83.7%	71.5%
17229	7	3	42.9%	.5%	84.2%	71.3%

KEY

* = ASSUMPTION THAT 61 PATIENTS IN MIFFLIN AND JUNIATA COUNTIES HAD OUTPATIENT CATARACT SURGERY AT FREE STANDING SURGERY CENTERS IN 1996

A = ZIP CODE

B = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD OUTPATIENT CATARACT SURGERY IN 1996

C = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD OUTPATIENT CATARACT SURGERY AT THE HOSPITAL IN 1996

D = HOSPITAL'S SHARE OF ZIP CODE

E = ZIP CODE'S INDIVIDUAL CONTRIBUTION TO TOTAL NUMBER OF OUTPATIENT CATARACT SURGERIES PERFORMED AT THE HOSPITAL IN 1996

F = CUMULATIVE ZIP CODES' CONTRIBUTION TO TOTAL NUMBER OF OUTPATIENT CATARACT SURGERIES PERFORMED AT HOSPITAL IN 1996 ("LIFO")

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4: Turn SLIGHT RIGHT onto E 3RD ST.	0.62 miles
5: Turn RIGHT onto US-22/ US-522/ N JUNIATA ST. Continue to follow US-22.	32.23 miles
6: Take the ramp toward PA-26 N.	0.16 miles
7: Stay straight to go onto PENN ST.	0.73 miles
8: Turn RIGHT onto 4TH ST.	0.19 miles
9: Turn LEFT onto MOORE ST.	0.16 miles
10: Turn RIGHT onto 6TH ST.	0.07 miles
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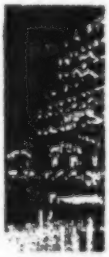

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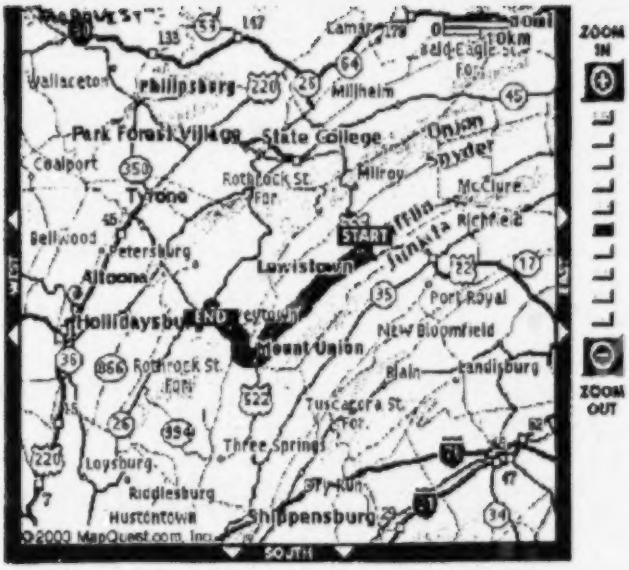

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3:	JACKSONVILLE RD becomes E HOWARD ST.	0.84 miles
4:	Turn LEFT onto N ALLEGHENY ST/ PA-144.	0.09 miles
5:	Turn RIGHT onto W HIGH ST/ PA-550 S. Continue to follow PA-550 S.	0.15 miles
6:	Turn LEFT onto PA-150/ PA-550/ S WATER ST. Continue to follow PA-150.	6.53 miles
7:	PA-150 becomes E COLLEGE AVE/ PA-26 S.	2.75 miles
8:	Take the ramp toward PENN STATE UNIVERSITY.	0.11 miles
9:	Turn SLIGHT LEFT to take the ramp toward PHILIPSBURG.	0.04 miles
10:	Turn SLIGHT RIGHT onto N UNIVERSITY DR.	0.74 miles
11:	Turn RIGHT onto PARK AVE.	0.12 miles

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3: JACKSONVILLE RD becomes E HOWARD ST.	0.16 miles
4: Turn LEFT onto MCALLISTER ST.	0.30 miles
5: Turn LEFT onto PA-550/ E BISHOP ST. Continue to follow PA-550.	1.16 miles
6: Merge onto PA-26 S.	3.63 miles
7: Turn LEFT onto S HARRISON RD.	0.53 miles
8: Turn SLIGHT LEFT onto S MAIN ST/ PA-144. Continue to follow PA-144.	8.58 miles
9: Take US-322 E.	15.53 miles
10: Take the exit toward ELECTRIC AVE.	0.12 miles
11: Turn LEFT onto ORI VALLEY RD.	0.25 miles
12: Turn LEFT onto ELECTRIC AVE.	0.35 miles
13: Turn LEFT onto 4TH ST.	0.08 miles

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EXHIBIT G

1996 INPATIENT MIGRATION DATA ORGANIZED ACCORDING TO ZIP CODE'S IMPORTANCE TO THE HOSPITAL

A	B	C	D	E	F	G
17044	3107	2647	85.2%	37.6%	37.6%	85.2%
17059	769	612	79.6%	8.7%	46.3%	84.1%
17051	532	360	67.7%	5.1%	51.4%	82.1%
17841	453	339	74.8%	4.8%	56.2%	81.4%
17084	401	324	80.8%	4.6%	60.8%	81.4%
17063	386	318	82.4%	4.5%	65.3%	81.4%
17004	414	309	74.6%	4.4%	69.7%	81.0%
17082	305	254	82.2%	3.6%	73.3%	81.1%
17009	268	223	83.2%	3.2%	76.5%	81.2%
			MINIMAL MARKET			
17049	282	208	73.8%	3.0%	79.4%	80.9%
17099	227	198	87.2%	2.8%	82.2%	81.1%
17058	254	193	76.0%	2.7%	85.0%	80.9%
17094	228	166	72.8%	2.4%	87.3%	80.7%
			OPTIMAL MARKET			
17066	723	148	20.5%	2.1%	89.4%	75.5%
17021	107	68	63.6%	1.0%	90.4%	75.3%
17035	80	59	73.8%	.8%	91.2%	75.3%
17029	59	52	88.1%	.7%	92.0%	75.4%
			MAXIMAL MARKET			
17086	198	42	21.2%	.6%	92.6%	74.1%

KEY

A = ZIP CODE

B = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD INPATIENT SURGERY IN 1996

C = TOTAL NUMBER OF PATIENTS IN ZIP CODE WHO HAD INPATIENT SURGERY AT THE HOSPITAL IN 1996

D = HOSPITAL'S SHARE OF ZIP CODE

E = ZIP CODE'S INDIVIDUAL CONTRIBUTION TO TOTAL NUMBER OF INPATIENT SURGERIES PERFORMED AT THE HOSPITAL IN 1996

F = CUMULATIVE ZIP CODES' CONTRIBUTION TO TOTAL NUMBER OF INPATIENT SURGERIES PERFORMED AT HOSPITAL IN 1996 ("LIFO")

G = THE HOSPITAL'S SHARE OF THE AGGREGATE ZIP CODES ("LOFI")

ORDER

In accordance with the court's findings of fact and conclusions of law, IT IS HEREBY ORDERED THAT:

(1) The following exhibits are admitted into the record: Def. Exs. 226(A) (6 and 7), (15-18), (33), (35), (45), (50), (52), 226(I), (J)(1), 227(A)(1), (6-20), (E), (H), (I), (J) (3 and 5), and 231 (2, 10, 21, 29, and 40).

(2) The following exhibits are INADMISSIBLE and should be excluded from the record: Def. Exs. 226(A) (20 and 25), 226(J) (2-5), 231(19), (24), (28), (34), (37), (38), and (39);

(3) The Clerk of Court is directed to enter judgment in favor of Defendant and against Plaintiff on Counts I, II, and III of Plaintiffs' amended complaint;

(4) The Clerk of Court is directed to enter judgment as indicated by the court in its orders of May 21, 2001 – granting summary judgment in favor of Defendant on Counts I, IV, V, VI, VII, and VIII – and August 15, 2001 – granting Plaintiffs' motion for reconsideration as to Count I;

(5) Defendant's motion to strike Plaintiffs' proposed findings of fact and conclusions of law is DENIED AS MOOT;

(6) Defendant's motion to Plaintiffs' supplemental proposed findings of fact and conclusions of law is DENIED AS MOOT;

(7) The court will not entertain a motion for a new trial and will deny any such request *sua sponte*. If either party disagrees with any of the court's findings of fact or

conclusions of law, they should seek relief from the United States Court of Appeals for the Third Circuit; and

(8) The Clerk of court is directed to close the case file.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C.; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER INC.,	**: CIVIL NO. 1:CV-99-1100**
Plaintiffs,	
v.	
LEWISTON HOSPITAL,	
Defendant	

MEMORANDUM

(Filed Aug. 15, 2001)

Before the court are the parties' cross-motions for partial reconsideration of the court's May 21, 2001 Memorandum and Order, granting in part and denying in part cross-motions for summary judgment. (*Gordon v. Lewistown*, Civ. No. 99-1100, Mem. Op. (M.D. Pa. May 21, 2001) (hereinafter "Mem. Op.").) Also before the court is the motion of the Hospital and Healthsystem Association of Pennsylvania to file a [sic] amicus curie brief in support of Defendant's motion for reconsideration. The parties have briefed the issues, and the motions are ripe for disposition.

I. Background

The factual and procedural background of the instant action is explained at length in the courts May 21, 2001 Memorandum and Order which is incorporated by reference. Pertinent to the instant motions is the following background: Plaintiffs filed an amended complaint on

February 2, 2000, stating eight causes of action under the Sherman Antitrust Act, 15 U.S.C. §§ 1-2. Counts I, II, IV, V, and VI were brought pursuant to section 1 of the Sherman Act. Counts III, VII, and VIII were brought pursuant to section 2 of the Sherman Act. Defendant answered Plaintiffs' amended complaint with eighteen affirmative defenses. Plaintiffs placed Defendants' first and fourteenth affirmative defenses at issue in their motion for partial summary judgment. Said defenses included (1) Defendant's immunity from liability for money damages under the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* ("HCQIA") (first affirmative defense), and (2) Defendant's position that Plaintiffs' claims are frivolous, unreasonable, without foundation, and/or in bad faith, thereby entitling the Hospital to all costs and attorneys fees pursuant to 42 U.S.C. § 11113 (fourteenth affirmative defense).

On May 21, 2001, the court denied Plaintiffs' motion for summary judgment on Count I of their amended complaint and on Defendant's first and fourteenth affirmative defenses. The court also denied Defendant's motion for summary judgment on Counts II and III of the amended complaint. The court granted summary judgment in favor of Defendant on Counts I, IV, V, VI, VII and VIII. On June 4, 2001, Defendant and Plaintiffs filed timely motions for partial reconsideration.

Plaintiffs seek reconsideration of the following: (1) the court's dismissal of Count I; (2) the court's finding that Defendant's 1997 decision to revoke Dr. Gordon's clinical privileges (the "1997 revocation") was based on professional conduct that "affects or could affect adversely the health or welfare of a patient or patients" under HCQIA, 42 U.S.C. § 11151(9); and (3) the court's finding that

Plaintiffs' proffered evidence of a conspiracy between Geisinger and Defendant was insufficient as a matter of law. Plaintiffs also ask the court to reconsider its admission of Defendant's Exhibits F, I, R, V, X, 1, and 19 as per the court's Modifying Order of May 21, 2001. Defendant moves the court to reconsider its decision with regard to the following: (1) the applicability of the solicitation exception to HCQIA immunity in the instant action; (2) the court's determination that there is no economic interest requirement for a tying claim (Count II); and (3) the court's denial of Defendant's motion for summary judgment on Plaintiffs' attempted monopolization claim (Count III).

II. Legal Standard: Motion for Reconsideration

A motion for reconsideration is not to give litigants a second bite of the apple to reargue their positions. It is well settled that a court will grant a motion for reconsideration only "to correct manifest errors of law or fact or to . . . [consider] newly discovered evidence." *Harsco Corp v. Zlotnicki,* 779 F.2d 906, 909 (3d Cir. 1985). Thus, a motion for reconsideration is improper unless: (1) new evidence has come to light which, had such evidence been discovered previously, could have affected a court's decisions; (2) the law on an issue has changed since the court's consideration of that issue; or (3) the court has made a manifest error of existing law.

III. Discussion

During the summary judgment phase of the instant action, the court was generous in allowing briefs to be

submitted that approximated up to 70 pages in length. Many of the arguments raised by the parties in their motions for reconsideration have been fully briefed and argued in previous stages of the litigation. The court admonishes the parties for requiring the court to expend judicial resources to weed through matters previously raised and addressed in order to ferret out meritorious arguments. The court will deny the parties' motions for reconsideration on the following issues without further discussion because the parties have simply used their motions for reconsideration to reargue their positions: (1) the court's finding that Defendant's 1997 decision to revoke Dr. Gordon's clinical privileges was based on professional conduct that did or had the potential to adversely affect patient health and welfare;[1] (2) the court's finding that Plaintiff has failed as a matter of law to raise

---

[1] Mem. Op. at 30-32. The court finds extremely disconcerting the statement in Plaintiffs' motion for reconsideration: "The [Memorandum] Opinion appears to recognize that the Hospital's expulsion of Dr. Gordon 'was based entirely on Dr. Gordon's violation of' Paragraph 3 and *not* because of any independent concern that Mrs. Seecora's health or welfare was threatened by the truthful and vital information that Dr. Gordon conveyed." (Pl. Br. in Supp. of Mot. Recon. at 10 (emphasis in original).) Plaintiff has misread and/or misinterpreted the court's opinion on this issue. The portion of the court's opinion cited by Plaintiffs states: "*Plaintiffs assert* 'the Hospital concedes that the expulsion was based entirely on Dr. Gordon's violation of' the Conditions of reappointment. . . . *However, what Plaintiffs neglect to note is that the purpose of the Conditions of Reappointment was to deter conduct that would adversely affect the health or welfare of patients,* most notably harassing and intimidating telephone calls to elderly patients." (Mem. Op. at 30 (emphasis added).) Thus, the court merely stated Plaintiffs' argument regarding the reason for Dr. Gordon's expulsion, but went on to *reject* that position. The court's rejection of this argument was not subtle, and if Plaintiffs merely misinterpreted it, than the court instructs Plaintiffs to scrutinize future opinions more closely.

a triable issue of fact regarding a conspiracy between Geisinger and Defendant;[2] (3) the court's denial of Defendant's motion for summary judgment on Plaintiffs' tying claim (Count II);[3] (4) the court's determination that there remain triable issues of fact as to the relevant geographic market;[4] and (5) the court's May 21, 2001 Modifying Order.

The court will now address the merits of the parties motions for reconsideration as to (1) HCQIA immunity; (2) Count I of Plaintiffs' amended complaint; and (3) Plaintiff's attempted monopolization claim.

A. HCQIA Immunity[5]

The court will here reconsider its determination that the applicability of HCQIA immunity turns on the issue of Dr. Gordon's subjective intent in contacting Mrs. Seecora and mailing a letter criticizing Dr. Nancollas to over thirty people. In order for a decision of a professional review body to be entitled to HCQIA immunity, the statutory definition of "professional review action" must be met. *See* 42 U.S.C. §§ 11151(9), 11112(a). The definition section of HCQIA provides an extensive definition of professional review actions:

> The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on

---

[2] Mem. Op. at 34-41.

[3] Mem. Op. at 43-45.

[4] Mem. Op. at 21-25

[5] For a full analysis of HCQIA immunity, see the court's May 21, 2001 Memorandum Opinion at 25-34.

> the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. . . . In this title, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –
>
> > (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business.

42 U.S.C. § 11151.

In the summary judgment briefs submitted to the court, Plaintiffs argued that Dr. Gordon's conduct for which his clinical privileges were revoked was "intended to solicit or retain business," and therefore HCQIA does not provide immunity from damages. In response, Defendant argued at length that Dr. Gordon's purpose or intent was something other than to solicit or retain business when he engaged in conduct that violated the Conditions of Reappointment. (Def. Br. in Opp. to Pl. Mot. Summ. Jud. at 24.)

The court at the summary judgment stage focused solely on these arguments proffered by the parties, and determined that there remained issues of material fact as to Dr. Gordon's subjective intent. (Mem. Op. at 28.) In so deciding the court overlooked Defendant's alternative argument that "no evidence exists, in this record, that the professional review action, arising from Dr. Gordon's telephone call to Mrs. Seecora, was 'primarily' (or even secondarily) based on Dr. Gordon's efforts to solicit or retain business." (Def. Br. in Opp. Pl. Mot. Summ. Jud. at

28.) Instead, Defendant argued that the decision to revoke Dr. Gordon's privileges was primarily based upon his violation of the Conditions of Reappointment. Nowhere, however, did Defendant take the position that Dr. Gordon's subjective intent was immaterial.

Upon motion for reconsideration, Defendant argues that the court erred in placing its focus on Dr. Gordon's subjective intent. Defendant asserts that "immunity protection does not hinge on a disruptive physician's subjective competitive intent. Otherwise HCQIA immunity is a dead letter because every disruptive physician will claim that his or her unprofessional conduct was nothing more but a subjectively intended 'competitive act.'" (Def. Br. in Supp. Mot. Recon. at 4.) Defendant contends that HCQIA's plain meaning, legislative history, and interpretive case law indicate that the court should not allow a physician's subjective intent to eviscerate the purposes of the statute.

In addition to the briefs of the parties, also before the court is an amicus brief filed by the Hospital and Healthsystem Association of Pennsylvania (the "Hospital Association") in support of Defendant's motion for reconsideration.[6] The Hospital Association also contends that the court erred by focusing on Dr. Gordon's subjective intent in determining whether HCQIA immunity is appropriate:

> What the solicitation exception actually excludes is a review action based upon the mere fact that

---

[6] The court initially deferred its ruling on whether the Hospital and Healthsystem Association's motion to file said brief would be granted. (See Order dated June 7, 2001.) The court will grant said motion.

> a physician has engaged in activities with the intent to solicit or retain business; it does not exclude actions taken on the basis of the review committees reasonable conclusion that the physician's activities (whether or not intended to solicit business) are unprofessional.

(Amic. Br. at 2.)

The court finds the arguments of Defendant, and more significantly of the Hospital Association, compelling. For the reasons that follow, the court will grant Defendant's motion for reconsideration on the issue of HCQIA immunity. "It is elementary that the meaning of the statute must, in the first instance, be sought in the language in which the act is framed, and if that is plain . . . the sole function of the courts is to enforce it according to its terms." *Abdul-Akbar v. McKelvie,* 239 F.3d 307, 312 (3d Cir. 2001). In its disposition of the summary judgment motions, the court misconstrued the wording of the statute, stating that it excludes from the definition of professional review action, "actions taken against physicians for conduct that is 'primarily based on . . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business.'" (Mem. Op. at 26.) However, the statute actually states that "an *action* is not considered to be based on the competence or professional conduct of a physician if *the action is primarily based on* . . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." 42 U.S.C. § 11151(9)(B) (emphasis added). The clause "primarily based on" refers not to the physician's conduct, but to the defendant hospital's action. Thus, the court erred in applying the "primarily

based on" clause to the physician's conduct rather than to Defendant's revocation of Dr. Gordon's clinical privileges.

While there is no binding authority on this issue, the court does find persuasive the analyses of other courts. In *Manion v. Evans*, No. 3:89CV7436, 1991 WL 575715 (N.D. Ohio July 8, 1991), the plaintiff physician sued the hospital that he had been working at when the hospital decided not to offer him a contract for his services. *Id.* at *3. The plaintiff alleged that the peer review action had been motivated by considerations that fell within the solicitation exception, 42 U.S.C. § 11151(9)(B). *Id.* at *8. The plaintiff in *Manion* had produced evidence that at least three individual defendants had motives other than patient safety in making the peer review decision. *Id.* at *9. However, the court determined that the plaintiff had "not produced any evidence to challenge the motivation of the Committee itself. In fact, the only evidence before the court indicates that the Committee was concerned about the quality of pathological services being provided at the hospital." *Id.* at *9. Other district courts have similarly focused on the motivations of the peer review committees rather than on the subjective intent of the plaintiff physicians. *See, e.g., Rogers v. Columbia-HCA*, 971 F. Supp. 229, 234 (W.D. La. 1997) (finding that, despite some competition between the peer review committee and the disciplined physician, "the primary reason for the action against [the plaintiff] was his professional competence").

Thus, the question before the court is whether Defendant's action of revolting Dr. Gordon's clinical privileges was primarily based on his engaging in competitive behavior. The court has already determined that the revocation of Dr. Gordon's clinical privileges was "based on the competence or professional conduct of an individual

physician (which conduct affects or could affect adversely the health or welfare of a patient or patients)," and that Plaintiffs failed to show that the procedural prerequisites of HCQIA were not met. (Mem. Op. at 29-34.) These findings remain unchanged as a result of the present motions for reconsideration. Furthermore, Plaintiffs have failed to present evidence that the peer committee as a whole was motivated by improper considerations in deciding to revoke Dr. Gordon's clinical privileges. Therefore, the court will grant Defendant's motion for reconsideration on the issue of HCQIA immunity. The court finds that Defendant is immune from liability for economic damages that Dr. Gordon allegedly suffered as a result of the peer review activities.

B. Count I: Contract in Restraint of Trade

Section 1 of the Sherman Act provides that "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is hereby declared to be illegal." 15 U.S.C. § 1. In addressing Count I of Plaintiff's complaint which alleged that the Conditions of Reappointment constituted an unreasonable restraint on trade, the court found ~~that~~ summary judgment should not be granted in Plaintiff's favor because there remained issues of fact as to the relevant geographic market.[7] (Mem. Op. at 21-25.) However, the court granted summary

[7] The court addressed the issue of relevant geographic market in the context of a full rule of reason analysis of the contract. Plaintiffs may satisfy their initial burden of showing anticompetitive effects by establishing that Defendant possessed market power. *See United States v. Brown Univ.*, 5 F.3d 658, 668 (3d Cir. 1993).

judgment in favor of Defendant on several of Plaintiffs' section 1 claims upon a finding that Plaintiffs had failed to establish a genuine issue of fact as to the existence of a conspiracy between Defendant and Geisinger. (*Id.* at 34-41.) The court inadvertently included Count I in its list of Counts that cannot be maintained in the absence of a conspiracy. As Count I alleges that the Conditions of Reappointment was a "contract" that violated the Sherman Act, the court erred in granting summary judgment in favor of Defendant on that basis. Accordingly, the court will grant Plaintiffs' motion for reconsideration on Count I.[8]

C. Count III: Attempted Monopolization

Defendant further moves for reconsideration of the court's denial of Defendant's motion for summary judgment on Plaintiffs' attempted monopolization claim. In order to succeed on an attempted monopolization claim, a plaintiff must show that the defendant (1) had specific intent to monopolize the relevant market, (2) engaged in anti-competitive or exclusionary conduct, and (3) possessed sufficient market power to come dangerously close to success. *Barr Laboratories, Inc. v. Abbott Laboratories*, 978 F.2d 98, 111 (3d Cir. 1992) (gathering cases). Addressing the cross-motions for summary judgment, the court addressed the third part of the test for an attempted

[8] In response to Plaintiffs' motion for reconsideration, Defendant does not contend that the Conditions of Reappointment constitute a contract that, standing in isolation from any concerted activity, could violate section 1 of the Sherman Act. Instead, Defendant reargues the sufficiency of Plaintiffs' evidence to establish a section 1 claim. The court will not readdress this issue.

monopolization claim and found that issues of fact remained as to market power. (Mem. Op. at 48.) However, the court did not address the first prong, e.g. whether Defendant had the specific intent to monopolize the relevant market. While the court's omission of a discussion on this issue constituted an oversight,[9] it would not have changed the court's decision.

At the summary judgment stage, Plaintiffs argued at length that Defendant engaged in anti-competitive conduct. Plaintiffs presented evidence that the Hospital agreed to divide markets with Geisinger for outpatient facility services, that the Hospital viewed another medical center as an opportunity to "counter" Dr. Gordon's facility, that the Hospital delayed providing an agreement to transfer patients from Dr. Gordon's facility, and that an anesthesiologist may have experienced pressure from the Hospital CEO not to practice at Dr. Gordon's facility. (Pl Br. in Opp. to Def. Mot. Summ. Jud. at 49-51.) While the court has determined that the 1996 suspension and the 1997 revocation of Dr. Gordon's clinical privileges were motivated by the Hospital's quality health care concerns, Plaintiffs have also alleged other behavior that a jury could find to be anti-competitive conduct.

Anti-competitive conduct is defined as conduct that does not have a legitimate business purpose. *Trace X Chemical, Inc. v. Canadian Indus. Ltd.*, 738 F.2d 261, 266

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[9] Defendant originally raised the issue in its motion for summary judgment, briefly arguing that "the use of peer review procedures does not imply an anti-competitive state of mind," (Def. Br. in Supp. Mot. Summ. Jud. at 46), and that "a hospital may exclude an individual doctor based on that doctor's unprofessional conduct." (*Id.* (citing *Urdinaran v. Aaron*, 115 F. Supp.2d 484, 490 (D.N.J. 2000).)

(8th Cir. 1984) (citing *Becker v. Egypt News Co.*, 713 F.2d 363, 366 (8th Cir. 1983)). Anti-competitive conduct "makes sense only because it eliminates competition." *Id.* Plaintiffs in this action are not only Dr. Gordon individually, but also Alan D. Gordon, P.C., a professional corporation, and Mifflin County Community Surgical Center, Inc., a corporation. Furthermore, Plaintiffs have presented evidence to at least raise an issue of fact as to Defendant engaging in anti-competitive conduct.[10] Instead of countering this evidence, Defendant has focused only on the peer review actions. Therefore, the court cannot say as a matter of law that Plaintiffs' attempted monopolization claims must fail,[11] and the court will deny Defendant's motion for reconsideration on Plaintiff's attempted monopolization claim.

IV. Conclusion

In accordance with the foregoing, the court will deny Plaintiffs' motion for reconsideration as to the following: (1) the court's finding that the 1997 revocation was based on professional conduct that does or could adversely affect patient welfare; (2) the court's determination that Plaintiffs failed to raise an issue of fact as to a conspiracy between Defendant and Geisinger; and (3) the court's

[10] Plaintiffs' amended complaint does not limit its allegations of anti-competitive conduct to the disciplinary actions taken against Dr. Gordon. It included allegations regarding the transfer agreement (Amen. Comp. at ¶ 42.) Furthermore, the attempted monopolization claim addresses generally "the exclusionary acts and practices complained of herein." (*Id.* at ¶ 59.)

[11] As noted *supra*, the court will not readdress the issue of the relevant geographic market, which the court has already found to be a jury question.

admissibility findings contained in its May 21, 2001 Modifying Order. The court will grant Plaintiffs' motion for reconsideration of the court's grant of summary judgment in favor of Defendant on Count I of Plaintiffs' amended complaint.

Furthermore, the court will deny Defendant's motion for reconsideration of the court's determination that an economic interest is not required for a tying claim (Count II) and the court's denial of summary judgment on Plaintiffs' attempted monopolization claim (Count III). The court will grant Defendant's motion for reconsideration on HCQIA immunity, and therefore holds that Defendant cannot be held liable for economic damages to Plaintiffs arising out of the 1996 suspension or the 1997 revocation.

/s/ Sylva H. Rambo
SYLVIA H. RAMBO
United States District Court

August 15, 2001

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C.; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER INC.,	**: CIVIL NO. 1:CV-99-1100**
Plaintiffs,	
v.	
LEWISTON HOSPITAL,	
Defendant	

ORDER

(Filed Aug. 15, 2001)

In accordance with the foregoing memorandum of law, **IT IS HEREBY ORDERED THAT**:

(1) The motion of the Hospital and Healthsystem Association of Pennsylvania to file a [sic] amicus curie brief in support of Defendant's motion for reconsideration is **GRANTED**;

(2) Plaintiffs' motion for reconsideration is **DENIED** as to the following issues:

(a) the court's finding that the 1997 revocation was based on professional conduct that does or could adversely affect patient welfare;

(b) the court's determination that Plaintiffs failed to raise an issue of fact as to a conspiracy between Defendant and Geisinger; and

(c) the court's admissibility determinations contained in its May 21, 2001 Modifying Order.

(3) Plaintiffs' motion for reconsideration on Count I of the amended complaint is **GRANTED**.

(4) Defendant's motion for reconsideration is **DENIED** as to the following:

(a) the court's determination that an economic interest is not required for a tying claim (Count II); and

(b) the court's denial of summary judgment on Plaintiffs' attempted monopolization claim (Count III).

(5) Defendant's motion for reconsideration on HCQIA immunity is **GRANTED** such that Defendant cannot be held liable for economic damages to Plaintiffs arising out of the 1996 suspension or the 1997 revocation.

(5) [sic] All other parts of the court's May 21, 2001 Memorandum and Order remain unchanged.

/s/ Sylva H. Rambo
SYLVIA H. RAMBO
United States District Court

August 15, 2001

UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

No. 03-3370

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., a corporation; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, a corporation,

Appellants

v.

LEWISTOWN HOSPITAL

On Appeal from the United States District Court
for the Middle District of Pennsylvania
(D.C. No. 99-cv-01100)
District Judge: Honorable Sylvia H. Rambo

Present: SCIRICA, *Chief Judge,* SLOVITER, ALITO, ROTH, McKEE, RENDELL, BARRY, AMBRO, FUENTES, SMITH, FISHER and VAN ANTWERPEN, *Circuit Judges.*

SUR PETITION FOR REHEARING
WITH SUGGESTION FOR REHEARING EN BANC

The petition for rehearing filed by Appellants having been submitted to all judges who participated in the decision of this court, and to all the other available circuit judges in active service, and a majority of the judges who

concurred in the decision not having asked for rehearing, and a majority of the circuit judges of the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing is hereby DENIED.

BY THE COURT:

/s/ D. Michael Fisher
Circuit Judge

Dated: November 7, 2005
Henry S. Allen Jr., Esq.
George M. Sanders, Esq.
Steven B. Varick, Esq.
Robert B. Hoffman, Esq.
David E. Loder, Esq.
Susan M. Lapenta, Esq.
Jonathan B. Sprague, Esq.

STATUTORY PROVISIONS

The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

* * *

In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on –

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

42 U.S.C. §11151(9).

* * *

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal.

15 U.S.C. §1.

(6)

No. 05-1000

FILED
MAR 10 2006
OFFICE OF THE CLERK
SUPREME COURT, U.S.

In The
Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., A CORPORATION; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., A CORPORATION,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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COUNTERSTATEMENT OF QUESTIONS PRESENTED

1. Does The Petition Present Any Compelling Reason(s) For Granting The Writ of Certiorari?

2. Did The Third Circuit Properly Find That Dr. Gordon's Unreasonably Broad Construction Of The "Solicitation" Exception To The HCQIA Immunity Is Contrary To That Statute's Plain Meaning And Legislative History?

3. Did The Third Circuit Correctly Apply Traditional Rule Of Reason To The Peer Review-Based Conditions Of Reappointment As Opposed To The Per Se Liability Standard Or The Quick Look Doctrine?

STATEMENT PURSUANT TO RULE 29.6

Lewistown Healthcare Foundation is the parent corporation of Respondent Lewistown Hospital. No publicly held company holds 10% or more of the Hospital's stock.

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COUNTERSTATEMENT

Dr. Gordon is an ophthalmologist who was first appointed to the Medical-Dental Staff of Lewistown Hospital ("Hospital") in 1980. Throughout his tenure on staff, Dr. Gordon repeatedly engaged in conduct that was inappropriate, unprofessional and disruptive to the Hospital's orderly operation. The Hospital attempted to convince Dr. Gordon to change his behavior by imposing professional review actions in a tempered, deliberate and progressive manner. Dr. Gordon did not heed these warnings. Indeed, his unprofessional conduct not only continued, but escalated.

In 1992, for example, Dr. Gordon verbally attacked a nurse in the Hospital's Emergency Department. *Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa. Commw. Ct. 1998), *appeal denied*, 558 Pa. 623, 737 A.2d 784 (1999). Following an investigation of this incident, a hearing and an appeal, the Hospital's Board of Trustees ("Board") suspended Dr. Gordon from its Medical Staff for 28 days. The suspension was based on Dr. Gordon's conduct, which was found to be disruptive to the Emergency Department's orderly operations.

Even after this 28-day suspension, Dr. Gordon's unprofessional conduct continued unabated. The most disturbing complaints the Hospital received were from elderly patients. These patients complained that Dr. Gordon would call them at home and make disparaging comments about their ophthalmologist, Dr. Nancollas, a competitor of Dr. Gordon's. Twice, Hospital counsel wrote to Dr. Gordon's counsel warning that if there were additional complaints from patients an investigation would ensue. Despite these warnings, the Hospital received

additional complaints from elderly patients that Dr. Gordon had again placed unsolicited calls to them, criticizing their decision to use Dr. Nancollas as opposed to him.

In November 1995, the Hospital's Credentials Committee, a peer review body, reviewed Dr. Gordon's harassing calls made to elderly patients and other inappropriate conduct. The Credentials Committee determined that the previous 28-day suspension had not been severe enough to get Dr. Gordon's attention, so it recommended that Dr. Gordon's privileges be suspended for 45 days. In addition, the Credentials Committee recommended that evaluation of Dr. Gordon's reappointment application to the Medical Staff be postponed until after he had served the 45-day suspension.

Dr. Gordon was notified of the Credentials Committee's recommendation and of his right to request a hearing. Even before that hearing could be held, however, the Hospital received several additional complaints from patients, physicians and nurses regarding Dr. Gordon's disruptive conduct. As a result, Dr. Gordon was summarily suspended on April 19, 1996 pending exhaustion of his hearing and appeals rights on the 45-day suspension.

At the conclusion of the hearing on the 45-day suspension, an independent Hearing Officer upheld the Credentials Committee's recommendation. In doing so, the Hearing Officer condemned Dr. Gordon's harassment of elderly patients as "cruel." Dr. Gordon did not appeal the Hearing Officer's recommendation.

Consistent with its November 1995 recommendation, the Credentials Committee evaluated Dr. Gordon's application for reappointment to the Medical Staff in August 1996. In light of past behavioral problems, the Credentials

Committee seriously considered recommending that Dr. Gordon's reappointment to the Medical Staff be denied.

Instead, the Credentials Committee wrote to Dr. Gordon and advised him of the many concerns it had and invited him to provide assurances that he would conduct himself strictly in accordance with the behavioral standards outlined in the Hospital's Medical Staff Bylaws and Policies.

Although the Credentials Committee was less than satisfied with Dr. Gordon's response, it decided to give Dr. Gordon one final opportunity to conform his behavior to appropriate professional standards. The Credentials Committee outlined for Dr. Gordon specific conditions with which he would be expected to comply if he intended to remain on the Hospital's Medical Staff. After consulting with legal counsel, Dr. Gordon agreed to abide by these conditions and, on November 11, 1996, the Board reappointed Dr. Gordon to the Medical Staff subject to his strict adherence to the Conditions of Reappointment ("Conditions").

In June 1997, just six months after Dr. Gordon agreed to the Conditions, the Hospital learned of two violations. The first incident involved a letter sent by Dr. Gordon to approximately 30 people, including every member of the Board, which was highly critical of Dr. Gordon's competitor, Dr. Nancollas. Consistent with the Conditions, Dr. Gordon should have directed the letter to the President of the Medical Staff or the Chairperson of the Credentials Committee, with a copy to the Hospital's President. That, he did not do.

The second, and more serious, violation was a telephone call made by Dr. Gordon to the home of an elderly

woman, Mrs. Seecora. During that unsolicited call, which occurred on a Sunday afternoon, Dr. Gordon made disparaging remarks to Mrs. Seecora about her ophthalmologist, Dr. Nancollas, and about the surgery that Dr. Nancollas had recently performed. Mrs. Seecora was so upset by Dr. Gordon's telephone call that she complained to her daughter who immediately reported the incident to the Hospital.

Dr. Gordon was invited to meet with an Ad Hoc Committee comprised of the President of the Medical Staff, the Chairperson of the Credentials Committee and the Chairperson of the Department of Surgery to discuss these incidents. After listening to Dr. Gordon's version of events, the Ad Hoc Committee confirmed that Dr. Gordon had violated the Conditions. The Credentials Committee agreed and recommended the revocation of Dr. Gordon's Medical Staff appointment and clinical privileges.

Dr. Gordon was afforded a hearing. Following the hearing, the Hearing Officer upheld the recommendation that Dr. Gordon's appointment and privileges be revoked. The Hearing Officer's report provided as follows:

> Based on the evidence presented at the hearing, particularly Dr. Gordon's testimony, it is my opinion that the Hospital could not draft a condition, no matter how explicit, that would protect the Hospital and its patients from Dr. Gordon's poor judgment. In light of this and the conditions set forth in Paragraph 17 of the Board's letter of reappointment (that any confirmed violation of any of the above conditions shall result in the revocation of his current appointment and clinical privileges and his ineligibility to reapply for appointment and/or privileges for a period of five

(5) years), the Credentials Committee's recommendations are reasonable and supported by the evidence.

Following an appeal, the Board, as the Hospital's governing body, upheld the Hearing Officer's recommendation. Dr. Gordon challenged various aspects of the Conditions in two state court actions. Both of these were summarily dismissed and the dismissals were upheld on appeal.

Dr. Gordon, and two corporations of which he is the sole shareholder, then brought an antitrust action against the Hospital alleging multiple violations of Sections 1 and 2 of the Sherman Act. 15 U.S.C. §§ 1-2. The District Court granted summary judgment in favor of the Hospital regarding the majority of Dr. Gordon's antitrust claims that required, as one of their elements, a concerted action or conspiracy, finding no genuine issue of material facts that would support an inference of conspiracy. The District Court also determined that, pursuant to the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11101-11152, the Hospital was entitled to immunity from money damages regarding the professional review actions at issue. Thereafter, the District Court conducted a lengthy non-jury trial and entered judgment in favor of the Hospital on the few remaining antitrust claims that sought injunctive relief.

On appeal to the Third Circuit, Dr. Gordon raised multiple issues. The Third Circuit affirmed the comprehensive rulings of the District Court, which resulted in judgment for the Hospital on all claims.

REASONS FOR DENYING THE WRIT

I. The Petition Does Not Present Any Compelling Reason(s) For Granting The Writ Of Certiorari

Supreme Court Rule 10 provides, in relevant part, that "review on a writ of certiorari is not a matter of right, but of judicial discretion" and that "certiorari will be granted only for compelling reasons." Rule 10 further states that such "compelling reasons" may be found to exist where a United States Court of Appeals has rendered a decision that conflicts with a decision of another United States Court of Appeals on the same important matter, the United States Court of Appeals has decided an important federal question in a way that conflicts with the decision by the highest court of a state or where a United States Court of Appeals has decided an important issue of federal law in a way that conflicts with decisions of this Court. Furthermore, Rule 10 states that "[a] petition for writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law."

Dr. Gordon's Petition does not implicate any "compelling reasons" stated in Rule 10(b) for granting certiorari. Although the reasons cited in Rule 10 are not exclusive, this Court has held that it should "be consistent in not granting the writ of certiorari except in cases involving principles the settlement of which is of importance to the public, as distinguished from that of the parties, and in cases where there is a real and embarrassing conflict of opinion and authority between the Circuit Courts of Appeal." *Layne & Bowler Corp. v. Western Well Works*, 261 U.S. 387, 43 S. Ct. 422, 67 L. Ed. 712 (1923).

The Third Circuit's determination that Dr. Gordon failed to satisfy the "solicitation" exception to the "professional review action" in the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11101-11152, does not conflict, especially in light of the record, with this Court's precedent or with any other court of appeals. Moreover, certiorari should be denied when a given legal analysis has not been adequately tested and analyzed by the lower courts. This ensures that the Court's review will benefit from the collective wisdom of those who have considered, for example, the scope of the HCQIA's solicitation exception. Certiorari is particularly inappropriate when, as here, the Third Circuit is the only court of appeals that has considered the scope of the solicitation exception to the definition of a "professional review action."

Likewise, the finding of the District Court and Third Circuit of a vertical relationship between the Hospital and Dr. Gordon, which implicates physician discipline and peer review, is in accord with near unanimous case authority. To the extent that Dr. Gordon contends that this hospital-physician relationship is horizontal, as opposed to vertical, Rule 10 prescribes that a "petition for a writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law." S. Ct. Rule 10.

Accordingly, the Hospital urges that this Court deny certiorari on all questions presented.

II. The Third Circuit Properly Found That Dr. Gordon's Unreasonably Broad Construction Of The "Solicitation" Exception To The HCQIA Immunity Is Contrary To That Statute's Plain Meaning And Legislative History

Dr. Gordon seeks certiorari on the question of whether, on this record, the solicitation exception to a professional review action under the HCQIA applies. Dr. Gordon contends that the definition of "professional review action" under the HCQIA turns on whether the physician's conduct, from the physician's perspective, was intended to solicit or retain business. This interpretation is not supported by a plain reading of the HCQIA itself or the legislative history.

As the Third Circuit stated, the meaning of a statute must, in the first instance, be "sought in the language in which the act is framed, and if that is plain . . . the sole function of the courts is to enforce it according to its terms." *Gordon v. Lewistown Hospital*, 423 F.3d 184, 205 (3d Cir. 2005) (*quoting Abdul-Akbar v. McKelvie*, 239 F.3d 307, 312 (3d Cir.), *cert. denied*, 533 U.S. 953, 121 S. Ct. 2600, 150 L. Ed. 2d 757 (2001)). The Third Circuit also correctly determined:

> [t]he plain language of the solicitation exception focuses on the basis of the 'action' taken by the professional review body, not on the conduct of the physician precipitating the action – '**an action** is not considered to be based on the competence or professional conduct of a physician **if the action is primarily based** on . . . the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business.'

Id., 423 F.3d at 205 (citing 42 U.S.C. § 11151(9)(B)) (emphasis added).

The clause "primarily based on" refers not to the physician's subjective intent, but to the professional review body's basis for the challenged professional review action. Thus, as the Third Circuit concluded, "even when the solicitation exception is in play, immunity will be judged by applying the objective standard regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare." *Gordon*, 423 F.3d at 205.[1]

Importantly, Dr. Gordon **did not** challenge the Hospital's presumptive compliance with the § 11112 immunity standards, and thus he has conceded that the "basis" for the Hospital's action was the reasonable belief that it was in furtherance of quality health care, not his self-styled "solicitation" efforts.

Universal precedent applying an objective standard to determine immunity from money damages under 42 U.S.C. § 11112(a) further supports this "reasonable basis" construction. *See, e.g., Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 840 (3d Cir. 1999) ("Like other circuits, we have adopted an objective standard of reasonableness in this context.") (cases collected); *see also* H.R. Rep. 99-903 at 10, reprinted at 1986 U.S.C.C.A.N. at 6392-93 (adopting objective standard that a professional review action must

[1] In his Petition, Dr. Gordon repeatedly asserts (incorrectly) that the Third Circuit's standard was that "if a hospital believes that preventing protected conduct by physicians . . . will further quality health care or 'protect patients', a hospital would receive immunity." (Gordon Petition for Cert. at 12). However, as noted above, the Third Circuit's standard was an objective one.

be undertaken in the reasonable belief that it is in furtherance of quality health care and rejecting a "good faith" standard as being capable of being misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional review action).

Under Dr. Gordon's interpretation, a review action would never qualify as a "professional review action" as long as the offending physician subjectively intended, or characterized the unprofessional conduct as a "competitive act." Under Dr. Gordon's interpretation, the solicitation exception would become a license by which an offending physician could, with impunity, bully, badger, and abuse patients, all in the name of "competitive acts." A hospital would be powerless to put a stop to this abusive behavior.

In enacting the HCQIA, Congress sought to improve the quality of health care by encouraging professional self-regulation through immunity protection. 42 U.S.C. § 11101. Holding that a disciplined physician's subjective intent to "solicit" is all that is required to sidestep the immunity of the HCQIA would fundamentally undermine the HCQIA's self-regulatory goal and effectively chill peer review.[2] The Third Circuit shared this concern and correctly concluded:

> The record here establishes that the 1997 revocation of Gordon's Medical-Dental Staff privileges resulted from concern for patient welfare. Gordon's attempts to couch his telephone calls to

[2] Even the HCQIA is no defense against a well-heeled, disciplined physician who seeks vengeance through runaway, bad faith litigation. The District Court found that Dr. Gordon's goal was to bankrupt the Hospital through the relentless prosecution of ruinously expensive litigation. *Gordon*, 423 F.3d at 201 n.12.

> Mrs. Seecora to fit within the parameters of the solicitation exception are disingenuous based on the extensive record before this Court chronicling Gordon's continued inappropriate conduct undertaken to advance his personal agenda to the detriment of patient welfare. To hold otherwise on a record such as this would effectively chill effective peer review by permitting the subject of the peer review process to control the application of HCQIA immunity by couching his or her intentions to fit within the solicitation exception to 'professional review action.'

Gordon, 423 F.3d at 206.

Dr. Gordon's strained interpretation of the HCQIA as providing a total exclusion from HCQIA immunity for harmful and unprofessional conduct dressed up as business solicitation is absurd. Solicitation is no safe haven for abuse.

As the Third Circuit rightly observed:

> if HCQIA immunity hinged on the disruptive physician's subjective intent, every disruptive physician would claim that the unprofessional conduct being reviewed was intended for a competitive purpose in order to invoke the solicitation exception to professional review action.

Gordon, 423 F.3d at 205 n.14. A disruptive physician's self-serving "solicitation" gloss must not be allowed. Otherwise, the solicitation "exception" will swallow the HCQIA immunity "rule."

The Petition should not be granted as to Question Presented No. 1.

III. The Third Circuit Correctly Applied Traditional Rule Of Reason To The Peer Review-Based Conditions Of Reappointment As Opposed To The Per Se Liability Standard Or The Quick Look Doctrine

Dr. Gordon's Petition for a Writ of Certiorari contains a fundamental "disconnect" between its technical antitrust jargon and Dr. Gordon's real world unprofessional conduct. The Petition depicts Dr. Gordon's harassing and intimidating phone calls to vulnerable elderly patients simply as informational output. The Conditions of Reappointment, which were applied in the "vertical" context of peer review, are characterized as a "horizontal" information restraint. Antitrust buzzwords, however, neither mask nor excuse Dr. Gordon's long history of disruptive, abusive and harassing behavior.

Dr. Gordon has also attempted to repackage himself as a consumer champion. However, his sterilized version of the case completely ignores that the Hospital, through its peer review process, took measured, progressive steps over the course of years and in response to repeated complaints from patients. Ironically, the Board revoked the Medical Staff appointment of this self-proclaimed "consumer champion" because many of the alleged beneficiaries of his informational output, elderly cataract patients, complained to the Hospital about Dr. Gordon's rude, invasive and unsolicited telephone calls.

In his Petition, Dr. Gordon attacks the Conditions primarily as a per se or near per se violation of Section One of the Sherman Act. The vertical, peer review-based Conditions, however, cannot be squeezed into the ever narrowing per se or "near per se" niche.

In *Texaco, Inc. v. Dagher*, 2006 U.S. LEXIS 2023 (decided Feb. 28, 2006), this Court further narrowed the already narrow per se liability standard:

> Section 1 of the Sherman Act prohibits "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states." 15 U.S.C. §1. This Court has not taken a literal approach to this language, however. *See, e.g., State Oil Co. v. Khan*, 522 U.S. 3, 10, 118 S. Ct. 275, 139 L. Ed. 2d 199 (1997) ("This Court has long recognized that Congress intended to outlaw only *unreasonable* restraints.") (Emphasis added.) Instead, this Court presumptively applies rule of reason analysis, under which antitrust plaintiffs must demonstrate that a particular contract or combination is in fact unreasonable and anticompetitive before it will be found unlawful. *See, e.g., id.*, at 10-19 (concluding that vertical price-fixing arrangements are subject to the rule of reason, not *per se* liability). *Per se* liability is reserved only for those agreements that are "so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality." *National Soc. of Professional Engineers v. United States*, 435 U.S. 679, 692, 98 S. Ct. 1355, 55 L. Ed. 2d 637 (1978). Accordingly, "we have expressed reluctance to adopt per se rules . . . 'where the economic impact of certain practices is not immediately obvious.'" *State Oil, supra*, at 10 (quoting *FTC v. Indiana Federation of Dentists*, 476 U.S. 447, 458-459, 106 S. Ct. 2009, 90 L. Ed. 2d 445 (1986)).

Texaco, Inc., 2006 U.S. LEXIS 2023, *7-8.

Texaco, Inc. represents this Court's latest refusal to apply the per se liability standard to challenged conduct. There, Petitioners, Texaco, Inc. and Shell Oil Co., collaborated in a joint venture, Equilon Enterprises, to refine and sell gasoline in the Western United States under the original Texaco and Shell Oil brand names. The Respondents, a class of Texaco and Shell Oil service station owners, alleged that Petitioners engaged in unlawful price fixing when Equilon set a single price for both Texaco and Shell Oil brand gasoline. After Equilon began operations, the service station owners brought suit in district court alleging that, by unifying gasoline prices under two brands, Shell Oil and Texaco had violated the per se rule against price fixing. *See, e.g., Catalano, Inc. v. Target Sales, Inc.*, 446 U.S. 643, 647, 100 S. Ct. 1925, 64 L. Ed. 2d 580 (1980) (per curiam).

The district court awarded summary judgment in favor of Texaco and Shell Oil. The district court determined that the rule of reason, rather than a per se rule or the quick look doctrine, governed the service station owners' claim, and that, by eschewing rule of reason analysis, the service station owners had failed to raise a triable issue of fact.

The Ninth Circuit reversed, characterizing Shell Oil's and Texaco's litigation defense position as a request for an "exception to the *per se* prohibition on price fixing," and rejecting that request. *Id.* at *6. This Court consolidated and granted Texaco's and Shell Oil's separate certiorari petitions to determine the extent to which the per se rule against price fixing applies to joint ventures. (*Id.*)

Holding that the "pricing decisions of a legitimate joint venture do not fall within the narrow category of

activity that is per se unlawful under § 1 of the Sherman Act," this Court reversed the judgment of the Ninth Circuit:

> As a single entity, a joint venture, like any other firm, must have the discretion to determine the prices of the products that it sells, including the discretion to sell a product under two different brands at a single, unified price. If Equilon's price unification policy is anticompetitive, then respondents should have challenged it pursuant to the rule of reason. . . . But it would be inconsistent with this Court's antitrust precedents to condemn the internal pricing decisions of legitimate joint venture as *per se* unlawful.

(*Id.* at *10, *12) (footnotes omitted).

In a footnote, this Court also rejected the service station owners' alternative contention that Shell Oil and Texaco should be held liable under the quick look doctrine. As this Court observed:

> To be sure, we have applied the quick look doctrine to business activities that are so plainly anticompetitive that courts need undertake only a cursory examination before imposing antitrust liability. *See, California Dental Ass'n v. FTC*, 526 U.S. 756, 770, 119 S. Ct. 1604, 143 L. Ed. 2d 935 (1999). **But for the same reasons that per se liability is unwarranted here, we conclude that petitioners cannot be held liable under the quick look doctrine.**

Texaco, Inc., 2006 U.S. LEXIS 2023, *10 n.3 (emphasis added).

If it is not per se, or near per se, illegal under Section 1 of the Sherman Act for a non-sham joint venture to set

the prices at which it sells its products, a hospital's application and enforcement of conditions of reappointment on a chronically disruptive staff physician, in the vertical context of peer review, is not, based on this Court's precedent, illegal per se or under the quick look doctrine.

In *Texaco, Inc.*, this Court recognized that:

> [a]s a single entity, a joint venture, like any other firm, must have the discretion to determine the prices of the products that it sells, including the discretion to sell a product under two different brands at a single, unified price.

Texaco, Inc., 2006 U.S. LEXIS 2023, *10.

This Court has likewise recognized a "hospital's unquestioned right to exercise some control over the identity and the number of doctors to whom it affords staff privileges." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 30, 104 S. Ct. 1551, 80 L. Ed. 2d 2 (1984). This real world recognition forms this Court's antitrust analysis.

Using *Hyde* as a starting point, lower courts have almost universally applied the rule of reason test, and eschewed the per se standard or quick look doctrine, when assessing the antitrust bona fides of hospital staffing decisions. *See, e.g., Diaz v. Farley*, 215 F.3d 1175, 1184 (10th Cir. 2000) ("Finally, the fact that the conduct at issue in this case concerns decisions relating to health care presents a further reason why we should be cautious in applying a per se test. Because agreements pertaining to the provision of health care services often raise issues of professional medical judgment, it is typically useful to apply a rule of reason approach. . . ."); *Betkerur v. Aultman Hospital Ass'n*, 78 F.3d 1079, 1093 (6th Cir. 1996) ("Indeed, Courts have generally concluded that the rule of reason

applies to practices based on medical considerations."); *BCB Anesthesia Care, Ltd. v. Passavant Memorial Area Hosp. Ass'n*, 36 F.3d 664, 667 (7th Cir. 1994) ("This case involves one hospital's decisions about staff privileges and staffing patterns. The cases involving staffing at a single hospital are legion. Hundreds, perhaps thousands of pages in West publications are devoted to the issues those circumstances present. Those cases invariably analyze those circumstances under the rule of reason – there is nothing obviously anticompetitive about a hospital choosing one staffing pattern over another or in restricting the staffing to some rather than many, or all. . . . A hospital has an unquestioned right to exercise some control over the identity and number to whom it accords staff privileges. . . . Malpractice concerns, quality of care, market perceptions, cost, and administrative considerations may all impact those decisions.") (case citations omitted); *Flegel v. Christian Hospital*, 4 F.3d 682, 686 (8th Cir. 1993) ("The courts of appeals have generally examined the denial or revocation of hospital privileges under the rule of reason. . . ."); *Lie v. St. Joseph Hosp.*, 964 F.2d 567, 570 (6th Cir. 1992) (applying rule of reason to a claimed agreement to suspend a physician's surgical privileges); *Capital Imaging Associates v. Mohawk Valley Medical Associates*, 996 F.2d 537; 545 (2d Cir. 1993), *cert. denied*, 510 U.S. 947, 114 S. Ct. 388, 126 L. Ed. 2d 337 (1993) (applying rule of reason to a radiology group's exclusion from providing services to patients of an HMO); *Kiepfer v. Beller*, 944 F.2d 1213, 1221 (5th Cir. 1991) (applying rule of reason to a physician's claim that he was the target of a campaign by two other physicians to discourage referrals to him).

Commentators and case law are in accord:

> Allegations of a concerted refusal to deal arise frequently in the health care industry. Denial of hospital staff privileges is frequently alleged to be the product of a group boycott organized by competing health care providers. In such cases, the courts have generally applied the rule of reason, holding that a hospital must be allowed, in conjunction with its medical staff, to exclude individual doctors on the basis of their lack of professional competence or unprofessional conduct. Actions to enforce ethical rules by medical associations are also frequently alleged to constitute a group boycott. Again, the courts generally apply the rule of reason, examining whether the rules serve a legitimate purpose in establishing professional standards of care without unduly limiting competition among providers.

ABA Section of Antitrust Law, Antitrust Law Developments 118 (4th Ed. 1997) (citations omitted). The rule of reason governs challenges to peer review-based staffing decisions.

The Conditions also were drafted, applied and enforced in the vertical context of hospital peer review of a disruptive physician. The Third Circuit did not "err" in viewing the peer review relationship between the Hospital and Dr. Gordon as vertical rather than horizontal despite Dr. Gordon's self-proclaimed designation as a "potential competitor." Dr. Gordon, again, is plain wrong.

In *Business Electronics Corp. v. Sharp Electronics Corp.*, 485 U.S. 717, 108 S. Ct. 1515, 99 L. Ed. 2d 808 (1988), this Court ruled that "[r]estraints imposed by agreement between competitors have traditionally been denominated

as horizontal restraints, and those imposed by agreement between firms at different levels of distribution as vertical restraints." *Sharp*, 485 U.S. at 730 (footnote omitted). Both as a matter of law, and on this record, the alleged "restraints" at issue, the Conditions, are the product of a vertical relationship between the Hospital and its peer review of a chronically disruptive member of its Medical Staff. Dr. Gordon, as the District Court and Third Circuit both determined, was not in the role of a "competitor," whether actual or potential (except in his own mind), when the Conditions were imposed. Rather, the Conditions were applied in the context of Dr. Gordon's reappointment to the Hospital Medical Staff. An arrangement like this could not be any more vertical. Courts almost invariably view relationships between hospitals and their staff physicians as vertical. *See, e.g., Coffey v. Healthtrust, Inc.*, 955 F.2d 1388, 1392 (10th Cir. 1992) ("Any relationship which existed between the physicians and [Edmond Memorial Hospital, Inc.] . . . is vertical.").

The Conditions were agreed to in the course of Dr. Gordon's biennial reappointment to the Hospital's Medical Staff. This is quintessentially a vertical relationship. Both vertical price and non-price agreements are subject to the rule of reason. *Sharp*, 485 U.S. at 735-36 (rule of reason applicable to vertical non-price restraints); *State Oil Co.*, 522 U.S. at 10-19) (vertical price-fixing arrangements subject to rule of reason, not per se liability). Assuming the Conditions constitute a "restraint," they constitute a non-price vertical restraint and are subject to rule of reason analysis.[3]

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[3] Dr. Gordon's self-described status as a "potential competitor" is a canard. The District Court did not find that Dr. Gordon and the Hospital were competitors w[illegible]n, in November 1996, Dr. Gordon agreed

(Continued on following page)

For the same reasons that per se liability is unwarranted here, the Hospital is not liable under the quick look doctrine. *Texaco, Inc.*, 2006 U.S. LEXIS 2023, *10 n.3. In *California Dental Ass'n v. FTC*, 526 U.S. 756, 119 S. Ct. 1604, 143 L. Ed. 2d 935 (1999) ("CDA"), this Court instructed the lower courts to apply a quick look rule of reason analysis only when an observer with even a rudimentary understanding of economics could conclude that the arrangement in question would have an anticompetitive effect on customers and markets. *CDA*, 526 U.S. at 770.

In *CDA*, however, this Court rejected the quick look analysis for a horizontal restraint involving a near total suppression of price and quality consumer information among 75% of all dentists in California. It is simply incredible for Dr. Gordon to argue in favor of a quick look at a non-price vertical restraint between one hospital and a single physician – a hospital that sought to protect elderly patients from the "restrained" physician's bullying, harassing and intimidating phone calls. The Hospital imposed the Conditions to protect elderly patients, not gain market share.

This Court therefore should deny the Petition as to Questions Presented Nos. 2 and 3.

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to the Conditions of his reappointment to the Medical Staff. Dr. Gordon did not begin competing against the Hospital until after his privileges were revoked and his Surgi Center opened almost a year later. Dr. Gordon agreed to the Conditions as a member of the Hospital's Medical Staff seeking reappointment, not as a competitor.

CONCLUSION

For the reasons set forth above, the Lewistown Hospital respectfully requests that the Petition for a Writ of Certiorari be denied.

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ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., A CORPORATION; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., A CORPORATION,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

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REPLY TO COUNTERSTATEMENT

Lewistown Hospital's Brief In Opposition to the Petition for Writ of Certiorari ("Hospital Opposition") consists almost entirely of vituperative personal attacks on Dr. Gordon in which the Hospital claims that on some prior occasions Dr. Gordon acted unprofessionally and in a disruptive manner.[1] At issue in this case, however, is whether it is anticompetitive for a hospital to impose by agreement an information restraint that limits the content of truthful physician-patient communications concerning the comparative risks and benefits of different surgical procedures.

Nowhere in its Opposition does the Hospital specifically address the information restraints or even try to explain how its agreement, that restrains the content of a physician's truthful comparative information concerning different procedures that the physician may communicate to patients, is anything but anticompetitive. Instead, the Hospital seeks to shift the focus of this case to whether it was appropriate for the Hospital to insist that Dr. Gordon

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[1] The Hospital's personal attacks against Dr. Gordon are not supported by the record, were not tested through the litigation process below, and are not relevant to the matters before the Court. The Hospital had repeatedly made accusations in internal Hospital hearings in which it relied entirely on hearsay statements by persons who did not testify, and who Dr. Gordon was prohibited from contacting. Before trial, the district court ruled that the truth of the Hospital's accusations and the consequent internal findings of Hospital hearings would not be admitted for their truth, and barred Petitioners from challenging them. The district court, however, reversed its pre-trial evidentiary rulings a year and a half after trial (App. at 231), and then based its judgment almost entirely on the very facts it had barred the parties from litigating (simultaneously preventing motions for reconsideration). The Third Circuit, in an extensive footnote, addressed only the hearsay objection and concluded, erroneously, that the district court had discretion to admit hearsay for the truth of the matter asserted. App. at pp. 51-2, n.21.

agree to the information restraints because of the alleged complaints the Hospital received from several consumers.[2] The alleged complaints did not challenge the veracity of the information Dr. Gordon provided. Indeed, the Hospital has never claimed that Dr. Gordon gave patients information that was false or misleading. Accordingly, the Hospital's alleged justification (Dr. Gordon's purported bad conduct) does not support the content-based information restraints. Without such support, the information restraints are nothing more than blatant limitations on competition. *See, National Collegiate Athletic Ass'n v. Board of Regents of The University of Oklahoma*, 468 U.S. 85, 119 (1984) (restraints must be narrowly tailored to serve procompetitive goals). A hospital may not gag important comparative treatment information and hence impair competition because the hospital can point to a few consumers who dislike the information. *See, National Society of Professional Engineers v. U.S.*, 435 U.S. 679, 693-95 (1978) (defendant could not justify a restraint on the ground that competition will injure consumers).

The healthcare ramifications of this case are important. Both the Third Circuit and the district court held that Dr. Gordon is an excellent surgeon, that he offered patients a safer and less invasive surgical procedure than his competitor and that his competitor misled patients concerning the type of procedure he used. Indeed, the district court held that the procedure used by Dr. Gordon was the preferred procedure for removing cataracts by the mid-1990s. The Third Circuit and the district court nonetheless held that a hospital's efforts to prevent a superior

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[2] The only evidence at trial of a complaining patient was Mrs. Seecora who testified by deposition that the information Dr. Gordon gave her made her feel that she had made the wrong decision having Dr. Nancollas treat her. App. at 28.

surgeon from competing by giving patients comparative information about the "preferred procedure" and the older procedure is only subject to the most deferential antitrust scrutiny and that a hospital's efforts to enforce such a restraint is entitled to immunity from damage claims.

That is why the medical community is up in arms over the decision below, and many of its most prominent organizations seek to file *amicus* briefs supporting the Petition. Healthcare markets cannot function efficiently if patients cannot receive information informing them about treatment alternatives and information showing which of those alternatives is the "preferred procedure." Information restraints that prevent physicians from giving patients such information will only lessen competition between physicians and will insulate outdated and less efficient treatment methods from competition. Such restraints will also permit hospitals to limit the ability of physicians who need hospital privileges to open competing outpatient surgery centers.

The facts that are relevant to the legal issues here could not more plainly frame the importance of these issues. Dr. Gordon was promoting to his patients what was recognized as the superior treatment method and had taken significant steps to open an outpatient surgery center when the Hospital made him agree to the information restraints. Consequently, this case presents a critical opportunity for this Court to clarify and explain the type of antitrust analysis such information restraints should receive.

REASONS FOR GRANTING THE PETITION

I. The Hospital Misstates The Legal Issue Under HCQIA.

The Hospital's response is to set up a "straw man" issue under the Healthcare Quality Improvement Act ("HCQIA"). Without citation, the Hospital claims that Dr. Gordon's position is that the relevant statutory carve-out

from the definition of a "professional review action" turns on "whether the physician's conduct, from the physician's perspective, was intended to solicit or retain business." Hospital Opposition, p. 8. This is a red herring. Petitioners maintain simply that the statute means what it says – that a hospital has no HCQIA protection (and must therefore defend its actions on the merits) if the hospital's action is "primarily based on . . . [a physician's] advertising or engaging in other competitive acts intended to solicit or retain business."

It is undisputed that the Hospital primarily based its exclusion of Dr. Gordon on his call to a patient, Mrs. Seecora, which was a "competitive act intended to solicit or retain business." Both the Hospital and Mrs. Seecora interpreted Dr. Gordon's call as an effort by Dr. Gordon to solicit or retain Mrs. Seecora as a patient. (A9002-9005). Indeed, the district court found, as a matter of fact after trial, that Mrs. Seecora "felt that Dr. Gordon was trying to solicit her to use him to remove her remaining cataract." App. at 75. Thus, this case does not present the circumstance where a physician disingenuously and "subjectively" characterizes his conduct as competitive to avoid immunity, as the Hospital argues repeatedly. The conversation for which Dr. Gordon was expelled was unquestionably competitive conduct to solicit or retain business, conduct that falls squarely within the competitive act carve-out from HCQIA immunity. 42 U.S.C. § 11151(9)(B).

The HCQIA issue actually framed by the Petition – which the Hospital ignores – is whether a hospital has statutory immunity whenever it reasonably believes that its action against a doctor is "in furtherance of quality healthcare," even if its action is based on a physician's advertising or other competitive acts. The words of the statute provide that hospital actions based on physician advertising or other competitive acts are not entitled to immunity, regardless of the hospital's belief, even good faith belief. The Third Circuit held to the contrary: "even when the solicitation exception is in play, immunity will be

judged by applying the objective standard regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare." App. at 31-32. That is wrong, as explained in the Petition, and in the separate *amicus* briefs of the American Osteopathic Association and the American Association of Ambulatory Surgery Centers. It confuses and combines the separate statutory requirements of 42 U.S.C. § 11151(9) with those of 42 U.S.C. § 11112(a), and it creates an alternative definition for a "professional review action" found nowhere in the statutory definition.

The Third Circuit was the first court of appeals to interpret the statutory carve-outs from immunity. By nullifying the carve-outs and substantially broadening immunity from damages (leading to the corresponding denial of a jury trial), the Third Circuit's decision will deter future challengers, leaving this error to stand long into the future. That is why healthcare organizations representing potential competitors of hospitals – osteopaths, ophthalmologists and ambulatory surgery centers, for instance – have asked this Court to hear this case to correct the Third Circuit's immunity decision before any more damage is done.

II. The Hospital's Antitrust Analysis – Like The Third Circuit's – Relies On Labels And Categorization Inconsistent With This Court's Decisions.

The Hospital Opposition fails to address the substance of Petitioners' antitrust arguments. The Hospital addresses the antitrust issues by: (1) continuing its personal attacks against Dr. Gordon, (2) falsely claiming that Petitioners have argued that the information restraints are subject to *per se* condemnation, (3) erroneously claiming that this Court's decision in *Texaco, Inc. v. Dagher*, 2006 U.S. LEXIS 2023 (Feb. 28, 2006) requires full-blown rule of reason treatment of the information restraints at issue here, and (4) claiming that, regardless of the nature of the restraint or the actual economic reality underlying

the physician-hospital relationship, courts must characterize the physician-hospital relationship as always vertical and subject to deferential treatment under Section One of the Sherman Act.

First, the Hospital suggests this Court should ignore "technical antitrust jargon" and simply focus on Dr. Gordon's alleged "real world unprofessional conduct." Hospital Opposition, pp. 12, 19, 20. The complained-of conduct, however, was not that Dr. Gordon gave patients false or misleading information. Therefore, the Hospital has not and could not present a plausible claim that the information restraints, which directly restrained the content of truthful comparative information, were procompetitive. *See, supra*, pp. 1-2.

Second, the Hospital claims that Petitioners seek to have the information restraints condemned as *per se* unlawful. Hospital Opposition, p. 12. The Hospital's argument is frivolous because Petitioners did not claim in their Petition that the information restraints were subject to *per se* condemnation. Indeed, Petitioners did not present a *per se* theory to either the district court or the Third Circuit.

Third, this Court's decision in *Texaco, Inc. v. Dagher*, 2006 U.S. LEXIS 2023 (Feb. 28, 2006) has no relevance to this case. In *Dagher* this Court held that "it would be inconsistent with this Court's antitrust precedents to condemn the internal pricing decisions of a legitimate joint venture as *per se* unlawful" or to apply the "quick look doctrine." *Id.*, at p. *10. How courts should review the pricing decisions of lawful integrated joint ventures has no relevance to the level of antitrust scrutiny that should be given to an information restraint a hospital imposes by agreement on a physician or a potential competitor.

Finally, the Hospital apparently claims that quick look analysis is never applicable to restraints entered into by hospitals and physicians because physicians and hospitals are vertically related and the full-blown rule of reason test is the only one applicable to vertical restraints.

Hospital Opposition, pp. 16-20. The cases cited by the Hospital do not support such a sweeping statement and the Hospital does not dispute the economic analysis of the physician-hospital relationship presented in the Petition. For example, the Hospital cites *Business Electronics v. Sharp Electronics Corp.*, 485 U.S. 717 (1988) to support its argument that physician-hospital relationships are vertical. In *Sharp*, however, this Court stated that restraints are vertical when "firms at different levels of distribution" enter into agreements. The Hospital, however, has not identified any "distribution" relationship between the Hospital and Dr. Gordon that would make *Sharp* relevant here.

The only physician-hospital case the Hospital cites to support its claim that physician-hospital relationships are always vertical is *Coffey v. Healthtrust, Inc.*, 955 F.2d 1388 (10th Cir. 1992). The court in *Coffey*, however, did not make a general holding concerning the nature of all physician-hospital relationships. Instead, the court, with no analysis, held that the relationship between the plaintiff physicians and the defendant hospital were vertical. *Coffey*, however, involved an exclusive contract for radiology services. A contractual relationship whereby a hospital procures radiology services for its patients is significantly different from a hospital contract that restrains an ophthalmologist from providing information to his or her patients.

The Hospital's second mistake is its argument that a quick look analysis is completely different from the type of analysis used under the rule of reason. Several holdings by this Court and by courts of appeals have "steadily moved away from the dichotomous approach – under which every restraint of trade is either unlawful *per se* . . . or subject to a full blown rule of reason analysis." *Polygram Holding, Inc. v. FTC*, 416 F.3d 29, 34 (D.C. Cir. 2005). In *FTC v. Indiana Federation of Dentists*, 476 U.S. 447 (1986), and

California Dental Association v. FTC, 526 U.S. 756 (1999) this Court held that labels and pigeon holes cannot substitute for careful economic analysis. As this Court directed in *California Dental*, courts are supposed to perform a rule of reason analysis that is "meet for the case." 586 U.S. at 781. The D.C. Circuit accepted that direction, and recently described the law as follows: "the extent of the inquiry is tailored to the suspect conduct in each particular case." *Polygram Holding*, 416 F.3d at 34. Accordingly, the Hospital's claim that the information restraints are subject to the rule of reason, while it states the obvious, does not address the correct issue. The actual issue is the level of scrutiny the information restraints will receive under the rule of reason.

The only effort the Hospital makes to address that issue comes at the very end of its brief where it argues that an abbreviated rule of reason analysis is not appropriate here because in *California Dental* "this Court rejected the quick look analysis for a horizontal restraint involving a near total suppression of price and quality consumer information. . . ." Hospital Opposition, p. 20. This mischaracterizes the Court's opinion, which merely found that the Ninth Circuit had taken too quick a look at ethical rules that were "designed to avoid false or deceptive advertising" and that could well have had "a net procompetitive effect." *California Dental Ass'n v. FTC*, 526 U.S. at 771. Indeed, even in *California Dental*, this Court did not require a full rule of reason market analysis. Then, on remand, the Ninth Circuit held that the CDA's restraints were anticompetitive; however, because of the possible procompetitive benefits, the Federal Trade Commission needed to present some empirical evidence that the restraints had a net-anticompetitive effect. *California Dental Ass'n v. FTC*, 224 F.3d 942, 949 (9th Cir. 2000).

Here the information restraints, imposed on a potential competitor, barred entirely truthful and nondeceptive

promotional communications and are anticompetitive. And here also, it is the Hospital that is seeking refuge in rigid categories so that it never needs to assert a legitimate and plausible procompetitive justification for the information restraints.

Finally, the string of cases the Hospital cites to support its claim that the rule of reason applies here are not relevant to any issue raised in the Petition. Hospital Opposition, pp. 16-17. First, only one of the cases cited by the Hospital addresses the application of the quick look doctrine: *Lie v. St. Joseph Hospital*, 946 F.2d 567 (6th Cir. 1992). *Lie*, which was decided long before this Court's decision in *California Dental*, did not involve an information restraint, but rather the suspension of the plaintiff's privileges because of quality of care concerns. Further, the court in *Lie* simply treated the quick look doctrine as part of the rule of reason.

CONCLUSION

This case presents important antitrust issues – that antitrust analysis is driven by economic impact, not labels; that bans on truthful comparative information almost always impair competition; and that a restraint on potential competitors is just as pernicious as a restraint among existing competitors. As the Department of Justice and Federal Trade Commission recently explained, fundamental antitrust principles have not been uniformly applied in healthcare, to the great detriment of consumers. *Improving Health Care,* Report by The Federal Trade Commission and the Department of Justice (September, 2004). Further, by expanding immunity in direct contradiction of the statutory language, the Third Circuit's opinion will eviscerate private enforcement of those important principles and may prevent the Court from soon having other opportunities to address these issues. Consequently – not only

for the Petitioners here, but for the medical community at large represented by the *amici* – it is vitally important that the Court take this case and give direction to the courts of appeals.

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v.

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Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

MOTION FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* AND BRIEF FOR THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY IN SUPPORT OF THE PETITION

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v.

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Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

MOTION OF THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY FOR LEAVE TO FILE BRIEF AS *AMICI CURIAE* IN SUPPORT OF THE PETITION

Pursuant to Rule 37 of the Rules of this Court, the American Association of Ambulatory Surgery Centers ("AAASC") and the Outpatient Ophthalmic Surgery Society ("OOSS") request leave to file the accompanying brief as *amici curiae* in support of the petition for writ of certiorari.[1]

[1] Petitioner Mifflin County Community Surgery Center, which is a member of the *amici* organizations AAASC and OOSS, has provided financial support to *amici* to partially defray the cost of this brief, but neither it nor its counsel have otherwise participated in its preparation.

AAASC is one of the premier national non-profit professional associations dedicated to promoting the high quality, lower-cost, patient-centered care provided through ambulatory surgery centers ("ASCs"). AAASC has over 500 members comprising over 1500 ASC locations across the country; these members include individual centers, corporate members, professional organizations, and state associations. ASCs compete with hospitals and frequently provide outpatient surgical procedures at substantially lower cost.

OOSS is the leading ophthalmic ASC non-profit professional society, with membership of roughly 1000 ophthalmic surgeons who offer care through over 200 ophthalmic ASCs nationwide. OOSS's mission is to help ASC owners and ophthalmic surgeons utilizing ASCs to provide high quality, cost-effective surgical care through education, information, and advocacy. Ophthalmic ASCs compete directly with hospitals to provide surgical services related to cataracts, glaucoma, and refractive or vitreoretinal care. They serve as a competitive check on hospitals with respect to cost, standards of care, and patient satisfaction.

As a representative of ASCs, and the physicians who practice in them, *amici* have a vital interest in ensuring that ASCs can continue to provide convenient and patient-friendly alternatives to hospital care. Because ASCs offer many benefits that customers and payors desire, they have become increasingly popular in the past decade, often at the expense of hospital outpatient facilities that compete with ASCs for patient and government funds. At the same time, ASCs depend on hospitals due to federal and state laws requiring ASC physicians to have privileges at nearby hospitals. ASCs are often especially vulnerable in local areas where a single hospital has a strong market position. Thus, ASCs are placed in the challenging position of competing with the very same

hospitals on which they often must rely to become licensed and stay in business.

The Third Circuit's decision leaves ASCs, and the physicians who practice in them, especially vulnerable in two situations: (1) when the physicians face "peer review" performed at a hospital; and (2) in their first stages of operation, when they are still nascent. The court's analysis of both of these questions left ASCs and their related physicians more exposed than ever to anticompetitive behavior from a hospital. Thus, amici seek permission to submit this brief to address these two points of the Third Circuit's opinion.

First, ASC physicians must be able to practice without fearing inappropriate reprisals through the physician peer review process. The Health Care Quality and Improvements Act ("HCQIA") provides protection from antitrust damage suits in legitimate peer review situations. However, it also provides exceptions from that immunity for certain potentially anticompetitive behavior. The Third Circuit applied overly broad immunity to hospitals tasked with performing peer review, in a manner that effectively expunged the exceptions for potential antitrust violations from the statute. If uncorrected, the Third Circuit's decision would allow hospitals and others to engage in *exactly* the type of unchecked behavior that Congress intended its exceptions to prevent. This Court should grant certiorari in order to give effect to the plain language of the statute.

Additionally, *amici* seek recognition that ASCs are not required to open their doors before the antitrust laws properly may be applied to shield them against anticompetitive behavior. Despite the fact that the Petitioner in this case had applied for a Certificate of Need to open an ASC, and had taken further steps in pursuit of its license, the Third Circuit determined that Petitioner and Lewistown Hospital which also offered

outpatient care services "were not competitors in the relevant market" and that Petitioner's "competition in the facility services market did not commence until MCCSC opened more than one year later." App. at 41. Such a result conflicts with antitrust cases and principles which recognize that competition in its incipiency is actual competition in the market. Moreover, this result leaves ASCs particularly vulnerable where they either enter a market where a hospital is already entrenched or where their physicians must rely on hospitals for privileges without which ASCs cannot operate under federal or state law. *Amici* support the issuance of a writ of certiorari on this issue to settle this question, as the Third Circuit's erroneous decision contradicts both accepted case law and antitrust analysis.

Accordingly, *amici* respectfully request that their motion for leave to file the accompanying brief as *amici curiae* be granted to address these issues.[2]

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[2] Petitioners have consented to the filing of this *amicus brief*; Respondent Lewistown Hospital has not.

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RULES

Supreme Court Rule 10(a) 11

IN THE

SUPREME COURT OF THE UNITED STATES

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., A CORPORATION; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., A CORPORATION,

Petitioners,

v.

LEWISTOWN HOSPITAL

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

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BRIEF FOR THE AMERICAN ASSOCIATION OF AMBULATORY SURGERY CENTERS AND THE OUTPATIENT OPHTHALMIC SURGERY SOCIETY IN SUPPORT OF THE PETITION

INTEREST OF *AMICI CURIAE*

The American Association of Ambulatory Surgery Centers ("AAASC") and the Outpatient Ophthalmic Surgery Society ("OOSS") request leave to file the attached brief *amici curiae* in support of the petition for writ of certiorari.

Amici are leading professional organizations dedicated to providing high-quality, lower-cost health care through ambulatory surgery centers ("ASCs"). ASCs compete with hospitals in providing outpatient surgical services, and regularly offer these services at substantially reduced costs to patients, private payors, and the government via Medicare and Medicaid. The opening of an ASC will

often result in decreased charges and/or improved standards of care for outpatient surgery at nearby hospitals.[1]

Amici have a strong interest in ensuring that physicians active in the formation or operation of ASCs do not lose their hospital privileges for anticompetitive reasons via restraints masquerading as professional review actions. Specifically, they have an interest in assuring that the federal statute affording qualified immunity from antitrust damage claims for legitimate peer review activity in hospitals is not improperly extended to restraints directed at physicians' competitive acts – restraints outside the scope of statutory immunity by the plain text of the law. They also seek recognition that the antitrust laws protect them against a hospital's anticompetitive acts when they are perhaps most vulnerable, when they are just embarking upon operation. ASCs should be protected from hospitals' anticompetitive actions as soon as they have taken concrete steps toward opening or providing services through an ASC that make them potential or incipient competitors of hospitals, whether or not their doors have yet opened for business.

SUMMARY OF ARGUMENT

Over the last decade, ASCs have become an important source of competition to hospitals for outpatient surgical services. By offering convenient, high-quality, lower-cost options for patients and physicians, ASCs provide an

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[1] Testimony of David Shapiro, M.D., President, AAASC, before the Subcomm. on Health, Comm. on Ways & Means, U.S. House of Representatives regarding the Medicare Payment Advisory Comm'n Report on Medicare Payment Policies for Ambulatory Surgery Center Services. at 2 (Mar. 20, 2003) [hereinafter "Shapiro Testimony"], *available at* http://www.aaasc.org/advocacy/documents/AAASCTestimony2003.pdf.

important alternative to hospital care. At the same time, ASCs and the physicians who staff them are dependent on hospitals for staff privileges without which many cannot operate under federal and state law. This dependence could be abused by hospitals to quash the threat of additional ASC competition.

A physician's peer review action is one potential vehicle for such abuse. The Health Care Quality and Improvement Act, 42 U.S.C. §§ 11101-11152 (1986) ("HCQIA" or "the Act") is designed to set standards for immunity from treble antitrust damages for certain physician peer review actions. Because the statutory language clearly requires satisfaction of a two-part test to confirm that a review was (1) not based on a doctor's competitive behavior, which would fall outside the definition of a "peer review action"; and (2) reasonable, it was error for the Third Circuit to subsume the first test into the reasonableness inquiry of the second. This can only result in an improper broadening of the intended immunity.

The Third Circuit also misapplied applicable precedent in stating that a still nascent ASC could not have been a competitor of an existing hospital. Antitrust law recognizes that potential or incipient competition will often act as a check on the marketplace. ASCs need legal protection from anticompetitive conduct even before they open their doors.

REASONS FOR GRANTING THE PETITION

I. This Court Should Examine The Third Circuit's Rewriting Of The Test For HCQIA Immunity.

A. ASCs Provide Vital, Innovative, Lower-Cost Health Care Services That Merit Federal Protection From Anticompetitive Conduct.

ASCs play an increasingly important role in the provision of quality health care at reasonable cost to patients

throughout the country. In that role, they often pose a serious competitive threat to hospitals. These facilities, often owned by physician investors, provide surgical procedures to patients who do not require overnight care by physicians or other health care professionals.[2] As such, they compete directly with hospitals that provide similar services in either an inpatient or outpatient setting, often taking business away from them. Recognizing ASCs' potential to reign in health care spending by offering low-risk surgeries in a lower-cost and patient-friendly environment, Congress provided in the early 1980s that Medicare should cover the facility costs of ASCs for certain services as it did for hospital services. *See* Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 934, 94 Stat. 2599 (1980). Since then, with advances in technology, the range of services safely provided in ASCs and covered by Medicare and other payers has greatly expanded.

Since the 1980s, the number of ASCs has grown rapidly, doubling in the past decade and now totaling over 4,400.[3] There are many reasons for this growth. First, ASCs ensure benefits to patients and physicians alike. They offer consumers more convenient locations, briefer wait times on-site, shorter delays in scheduling surgery, and often lower

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[2] *See* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, § 2F, at 136, 140 (2003) [hereinafter "MedPAC 2003], *available at* http://www.medpac.gov/publications/congressional_reports/Mar03_Entire_report.pdf.

[3] *See* Fed. Trade Comm'n & Dep't of Justice, Improving Health Care: A Dose of Competition (July 2004), at Chapter 3, at 24, (July 2004) [hereinafter "FTC/DOJ Report"] *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf; Am. Soc'y of Anesthesiologists Newsletter, Vol. 69, "Hospital Contracts Survey: 2004 Data," (April 2005), *available at* http://www.asahq.org/Newsletters/2005/04-05/pracMgmt04_05.html.

coinsurance payments than hospital outpatient departments.[4] Their concentration in specialized procedures, using state-of-the-art medical technology in facilities staffed by specially trained personnel, enables them to provide better care at greater satisfaction to patients than more generalized care providers.[5] Physicians in turn benefit from the increased efficiencies of using facilities designed for specific outpatient procedures. *See* MedPAC 2003, *supra* note 2, at 140. Because physicians retain control over the surgical calendar at ASCs, they may schedule more surgeries per day, which increases their fee generation ability, improves productivity, and decreases downtime. *See* Casalino, "Focused Factories," *supra* note 5, at 5; Shapiro Testimony, *supra* note 1, at 4.

Second, innovations in technology have allowed ASCs to offer an increasing range of services as outpatient procedures, transforming the way some maladies are treated. In the late 1990s in particular, physicians began performing several high-volume procedures in an ambulatory care rather

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[4] *See* MedPac 2003, *supra* note 2, at 140 (noting ASC copayments of 20 percent as compared with hospital outpatient copayments of up to 55 percent). *See also* Medicare Payment Advisory Comm'n, *Report to the Congress: Medicare Payment Policy*, Table 3F-1, at 187 (2004) [hereinafter "MedPac 2004"], *available at* http://www.medpac.gov/publications/congressionalreports/June04_Entire_Report.pdf (noting ASC coinsurance tended to be 10 to 60 percent lower than hospital outpatient coinsurance).

[5] *See* Lawrence P. Casalino *et al*, "Focused Factories? Physician-Owned Specialty Facilities," *Health Affairs*, Vol. 22, No. 6 (Nov./Dec. 2003) at 5-6, *available at* http://aaasc.org/advocacy/documents/FocusedFactoriesHealthAffairs1103.pdf; Richard P. Kusserow, Inspector General, Dept. of Health & Human Servs., "Patient Satisfaction with Outpatient Surgery: A National Survey of Medicare Beneficiaries," at 3-4, (1989), *available at* http://oig.hhs.gov/oei/reports/oei-09-88-01002.pdf.

than inpatient setting. *See* MedPAC 2003, *supra* note 2, at 139. For example, advances in microsurgery and ultrasound techniques have permitted better cataract lens replacements to be performed safely and more frequently in ASC settings. *Id.*, at 140. Migrating services from the inpatient hospital environment to lower-risk, lower-cost outpatient settings allows patients and payors alike to reap these benefits and encourages further technological advances.

Finally, ASCs can offer cost benefits not just to patients who have smaller copays, but to the government as well. For example, cataract removal or lens insertion makes up about half of the Medicare funds received by ASCs, yet ASCs' Medicare reimbursement rates for these services are at least 19 percent lower than those charged by hospital outpatient departments. *See* MedPAC 2003, *supra* note 2, at 140 & Table 2F-2; FTC/DOJ Report, *supra* note 3, at 26.[6] Comparing Medicare reimbursement rates generally, the government pays higher rates to hospitals for 2,267 procedures, and higher rates to ASCs for only 280 procedures.[7] Recent legislation, effective January 1, 2007, brings all higher ASC reimbursements down to the level of those paid to hospital outpatient departments. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 5103, 120

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[6] In 2006, the rate gap between ASCs and hospitals for this procedure became even more disparate. *Compare* 70 Fed. Reg. 68734 (Nov. 10, 2005) (listing hospital reimbursement rate for cataract procedures with IOL insert at $1,387.71) *with* U.S. Dep't of Health & Human Srvs., Medicare Claims Process Manual, CMS 100-04, Change Request 4075 (Sept. 30, 2005) (noting 2006 ASC reimbursement rates for the procedure were unchanged at $973).

[7] *See* Lena Robins *et al.*, "Deficit Reduction Act of 2005 Enacts Sweeping Medicare & Medicaid Changes," *Mondaq*, Feb. 17, 2006, *available at* http://www.mondaq.com/i_article.asp_Q_articleid_E_37888.

Stat. 4, 40 (2006). In this way, ASCs are fulfilling the purpose for which they were intended by applying increasing pressure against hemorrhaging health care costs.

For all of these reasons, ASCs have become increasingly popular with both patients and physicians. Congress has increased the services for which ASCs can receive Medicare reimbursement, and those payments to ASCs have more than tripled between 1992 and 2002, with total Medicare payments of $1.9 billion to ASCs in 2002. *See* MedPAC 2004, *supra* note 4, § 3F, at 186.[8] These results have affected and will continue to impact the bottom line at hospitals, because hospitals would otherwise perform and receive facility fees for these services.

Despite – and in some ways because of – the success of ASCs, physicians who desire to work at or open an ASC sometimes face hurdles imposed by hospitals, particularly in local areas where a single hospital has a dominant market position. Medicare currently does not offer facility reimbursement for all surgical procedures, and some individual patients may have conditions requiring inpatient admission. Doctors whose practice depends on their ability to also perform procedures on a hospital inpatient basis must retain their hospital privileges in order to practice effectively. This dependence is especially keen where the law requires physicians practicing at an ASC to have hospital staff privileges and/or transfer agreements with hospitals. *See* App. at 83; U.S. Dep't. of Health & Human Srvs., Medicare

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[8] The Department of Health and Human Services announced that in 2008, Medicare will significantly expand the list of services for which ASCs receive facility reimbursement. *See* AAASC release, "Medicare Commits to Significantly Expand Coverage of Services Within ASC," *available at* http://www.aaasc.org/advocacy/MedicareCommitstoSignificantlyExpandCoverageofServicesWithinASC.htm.

State Operations Manual, App. L, § 416.41 (2004), *available at* http://www.cms.hhs.gov/manuals/downloads/som107_Appendicestoc.pdf.

A 2004 joint Federal Trade Commission and Department of Justice Antitrust Division report, produced after extensive hearings and submissions, records panelists' observations of the various ways in which hospitals have tried to thwart further ASC entry. *See* FTC/DOJ Report, *supra* note 3, Chapter 3, at 27.[9] Such practices included "revok[ing] privileges of physician-investors in ASCs, and us[ing] state certificate of need (CON) laws to inhibit ASC entry." *Id.* Because physicians often remain dependent on hospitals due to the hospital's position in the marketplace, they are vulnerable to such attacks and require the full protection provided to them by the federal antitrust laws.

B. HCQIA's Clear Language Limits Antitrust Immunity Where Hospitals Use The Peer Review Process In Certain Specified Respects.

The courts below granted Lewistown Hospital (the "Hospital") immunity from antitrust damages on the basis of HCQIA, enacted in 1986. HCQIA was designed to provide hospitals with legal protection from damage claims in connection with *bona fide* peer review of physician competence and professional conduct, while preserving full application of the antitrust and other laws to hospital actions based on enumerated competitive acts by physicians. Congress was concerned that absent immunity, physicians who were aggrieved by adverse peer review decisions would

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[9] *See id.* at 22 n.111 (discussing "economic credentialing" whereby hospitals facing competition from specialty providers revoke the admitting privileges of physicians involved with those providers).

bring non-meritorious but costly challenges to their peer reviews. *See id.*, § 11101.

HCQIA provides that "[i]f a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title," it shall not be liable for damages related to that action. *Id.*, § 11111(a)(1). Thus, the plain language of the Act requires an action to satisfy two tests to obtain immunity from damages: first, it must meet the definition set out in Section 11151(9), and second it must comply with additional standards in Section 11112(a).

The first test, Section 11151(9), defines a "professional review action" as "an action or recommendation of a professional review body which is taken . . . based on the competence or professional conduct of an individual physician." *Id.*, § 11151(9). Section 11151(9) further provides, however, that an action will not be deemed to be based on the competence or professional conduct of a physician – and therefore will not be a "professional review action" – if the action is primarily based on one of five exceptions, including "the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business." *Id.*, § 11151(9)(B).[10] These limits

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[10] The four other exceptions are: "the physician's association, or lack of association, with a professional society or association," "the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis," "a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional," and "any other matter that does not relate to the competence or professional conduct of a physician." 42 U.S.C. §§ 11151(9)(A), (C)-(E). These exceptions were inserted because

(continued....)

on the definition of "professional review action" are explicit and critical.

The second test, Section 11112(a), sets out additional standards necessary for a professional review action to qualify for immunity, including the reviewing body's "reasonable belief that the action was in the furtherance of quality health care." *Id.*, § 11112(a)(1).[11]

Contrary to the plain language of the Act, the Third Circuit effectively held that so long as an action meets the second test, the action or recommendation of a hospital's professional review body will automatically pass the first test and will be deemed a "professional review action" based on a physician's competence or professional conduct. Thus, according to the Third Circuit, "even when the solicitation exception [to the definition of professional review action] is in play, immunity will be judged by applying the objective standard [of the second test] regarding whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare." App. at 31-32. The Third Circuit's holding therefore eviscerates Congress's decision to categorically limit the range of actions entitled to immunity, while applying a presumptively reasonable

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"this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care." H.R. Rep. No. 99-903, pt. 1, at 6404 (1986).

[11] Section 11112(a) further states that "[a] professional review action shall be presumed to have met the preceding standards necessary for [immunity from damages] unless the presumption is rebutted by a preponderance of the evidence." Accordingly, Section 11112(a) will not even apply unless the act in question has already satisfied the definition of a "professional review action."

standard to a hospital's determination. The result expands the range of physician conduct that can be the basis for adverse action that qualifies for immunity and broader protection for anticompetitive behavior than the law provides.

In addition to defeating the plain language of the Act, this holding confounds the longstanding Supreme Court teaching that exemptions to the antitrust laws are to be construed narrowly. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 126 (1982); *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 231 (1979).

By subsuming the categorical exclusion of five specific exceptions in the test for reasonableness, the Third Circuit created a split with the Fifth Circuit, which had previously affirmed the separate application of both tests in their proper order. *See Rogers v. Columbia/HCA*, 971 F. Supp. 229, 234 (W.D.La. 1997) (determining act was a professional review action not fitting any exceptions set out in § 11151(9)(A)-(E) before proceeding to second test of § 11112(a)), *aff'd*, 140 F.3d 1038 (5th Cir. 1998) (mem). As such, the holding is appropriate for certiorari under Supreme Court Rule 10(a).

C. The Evisceration Of The Exceptions From HCQIA Immunity Conflicts With The Policies Underlying HCQIA And The Antitrust Laws.

In the 1970s and early 1980s, following the Supreme Court's decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975), antitrust law began to be applied actively in the health care field and in the professions. The litigation that followed challenged longstanding practices and premises in the professions and in the health field. The courts and antitrust enforcement agencies regularly confronted claims that restraints were justified because the competition engendered by otherwise professionally-proscribed market conduct would be harmful to patients or consumers – in

effect, that competition itself was unreasonable. Such restraints were often directed at advertising and solicitation activities; discounting; physicians practicing or cooperating with non-physician health care providers who compete with some physicians, such as nurse midwives, podiatrists, or chiropractors; affiliating with health maintenance organizations ("HMOs") or prepaid group health plans; and engaging in the salaried "corporate" practice of medicine. Numerous antitrust cases successfully challenged many of these restraints.[12] As the Supreme Court reemphasized in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978), an attempt to justify a restraint under the rule of reason "on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act."

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[12] *FTC v. Ind. Fed'n of Dentists*, 476 U.S. 447, 463-64 (1986) (rejecting claim that "an unrestrained market in which consumers are given access to the information they believe to be relevant to their choices will lead them to make unwise and even dangerous choices"); *Am. Med. Ass'n v. FTC*, 94 F.T.C. 701, 1037-39 (1979) (striking association's ethics code-based restrictions on advertising, corporate practice of medicine, and affiliation with prepaid group health plans), *aff'd as modified*, 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam by an equally divided Court*, 455 U.S. 676 (1982); *In re Mem'l Med. Ctr.*, 110 F.T.C. 541, 546-47 (1988) (consent order prohibiting medical center staff from denying or restricting hospital privileges to nurse midwives without basis); *Wilk v. Am. Med. Ass'n*, 719 F.2d 207, 211, 222-29 (7th Cir. 1983) (reversing jury verdict where jury instructions suggested that defendants' boycott of chiropractors was lawful if boycotting doctors sincerely believed chiropractics to be "dangerous quackery"); *In re State Volunteer Mut. Ins. Co.*, 102 F.T.C. 1232, 1236-37 (1983) (consent order prohibiting insurance company from applying different underwriting criteria to physicians affiliated with nurse midwives).

At the same time, physicians began using the antitrust laws to challenge individual peer review actions to which they objected, even where the action was based solely on their competence or professional conduct, unrelated to their pricing practices or other competitive activities. These cases generally failed – but not without exception. *See, e.g.*, *Patrick v. Burget*, 486 U.S. 94, 105 & n.8 (1988).[13] Congress, therefore, sought to provide qualified immunity to traditional peer review actions directed at a physician's competence or professional conduct, while being careful to exclude from immunity actions that suppress competitive activity by physicians, regardless of the belief of those imposing the discipline that the disciplinary action would further patient welfare and the quality of care provided.

HCQIA reflects careful line-drawing by Congress. Congress sought, on the one hand, to protect *bona fide* peer review focused on the competence or professional conduct of physicians. On the other hand, Congress recognized that restraints on certain types of physician activity were not appropriate for immunity. Among these activities were professional association memberships; fees; advertising and competitive acts intended to solicit or retain business; participation in HMOs or other health plans; and association with non-physician health care practitioners. Congress declined to extend immunity to restraints imposed to prevent a harm emanating from acts of competition themselves. Congress's approach tracks basic principles of antitrust law.

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[13] Bernard D. Reams, Health Care Quality Improvement Act of 1986: A Legislative History of Publ. L. No. 99-660 [hereinafter "HCQIA Hearings"], 101-02 (1990) (testimony of Arthur N. Lerner) (noting reaction to successful cases).

As a result, a "professional review action" can qualify for antitrust damages immunity if it meets specified standards, including fair process and a reasonable belief that the action furthers quality health care. But irrespective of the hospital's belief to the contrary, if the action is based primarily on the enumerated types of competitive acts by physicians, no immunity is provided. Disciplinary actions based on such conduct are fully subject to the antitrust laws. The plaintiff still may not win a suit -- after all, actions not immune under HCQIA are not presumed to violate the antitrust laws. *See* HCQIA Hearings, *supra* note 13, at 6393 ("failure to meet the standards of [the Act] creates no presumption with respect to the liability or lack of liability of a health care entity"). Many hospital peer review decisions, even though not exempt, have no harmful impact on competition or may actually foster it. Rather, where there is no immunity, plaintiffs merely get their day in court.

In holding that these categorical exceptions were subsumed by a reasonableness test focused on furtherance of quality health care, the Third Circuit undermined Congress's approach. Under that court's analysis, a hospital and its medical staff would be immune from antitrust damages for revoking the hospital privileges of a doctor who, for example, discounts his or her fees, joins an HMO, advertises, or collaborates with a nurse midwife, if the hospital reasonably believed that its actions furthered quality health care. This must be wrong. It was not Congress's intent to immunize a hospital that enforced a price-fixing or boycott scheme through peer review if it proffers a reasonable argument that it seeks to further quality health care.

Similarly, the Third Circuit's approach would extend antitrust damages immunity to hospitals that excluded physicians who advertised or otherwise communicated the relative cost, convenience or service advantages of ASC

services to prospective patients, so long as the reasonableness standards were met. Such a result could be devastating for non-hospital affiliated ASCs across the country, since doctors would have to, in effect, re-litigate in each instance whether the competition they sought to foster, and the hospital to restrain, would further quality health care or not. Such restraints do not qualify as professional review actions in the first place, and should enjoy no immunity.

The specific activity by Dr. Gordon that was the primary basis for the Hospital's disciplinary action is a fact issue, and whether that activity fits within any of the enumerated exceptions to the definition of "professional review action" is similarly a fact issue. Those issues are not properly resolved, however, by inquiries into whether the Hospital believed it was furthering quality health care and into the reasonableness of such a belief.

D. Legislative History Supports Application Of The Antitrust Exceptions From HCQIA Immunity.

The legislative history of the Act is compiled in HCQIA Hearings, *supra* note 13. The House's Committee Report on HCQIA confirms that "[t]o qualify for the [immunity] protection, the professional review action must meet the standards specified in section 102(a) [§ 11112(a)] and must be an action as defined in section 301(9) [§ 11151(9)]." *Id.* at 6391 (emphasis added). Other sections of the history concur that the immunity sections of Section 11112(a) were not meant to subsume the exceptions to professional review actions defined in Section 11151(9).[14] The Third Circuit's holding is to the contrary.

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[14] *See, e.g.*, HCQIA Hearings, *supra* note 13, at 47-49 (statement of Henry A. Waxman, Chairman, House Subcommittee on

(continued....)

II. This Court Should Consider Whether A Restraint Imposed On A Potential Or Incipient Competitor Can Be Horizontal In Nature Even If The Competitor Has Not Yet Commenced Operations.

The Third Circuit held that the restrictive "Conditions of Reappointment" that Dr. Gordon entered into with the Hospital on November 14, 1996 in order to be reinstated did not unlawfully restrain trade under the rule of reason. The court applied a "full" rather than a "quick look" rule of reason analysis, categorizing the relationship between Dr. Gordon and the Hospital as a "vertical" relationship between a single hospital and a single physician. In support, the court relied on a conclusion that "Gordon and the Hospital were not competitors in the relevant market in November 199[6][15] when he agreed to the Conditions. His competition in the facility services market did not commence until MCCSC opened more than one year later [in 1998]." App. at 41. In essence, the court found that to the extent proper analysis of an allegedly anticompetitive restraint depends on the existence of a relationship of competition between two

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Health and Environment) ("as *redrafted*, our bill applies *only* to professional review actions based on the competence or conduct of an *individual* physician. We completely *exclude* from the protections of the bill, any disciplinary action based on a doctor's membership or lack of membership in a medical society . . ."); *id.*, at 103, (statement of Arthur N. Lerner) (noting that the exclusions prevent application of immunity); *see also id.*, at 6404 (quoted *supra* at n.10, noting that antitrust exceptions were inserted due to concern for abuse for economic and related reasons).

[15] We note from Dr. Gordon's petition for certiorari that the Third Circuit's opinion makes a typographical error in listing the date of Dr. Gordon's agreement as November 1995 rather than 1996. *See* Pet. for Cert. at 24 n.2.

parties, no competitive relationship will be found when the new entrant has yet to open for business. The court erred and the implications of this error are grave. The court's error is starkly inconsistent with this Court's precedents, with decisions of other circuits, and with accepted antitrust analysis, importantly undermining a significant aspect of antitrust analysis in this field.

Antitrust law recognizes the centrality of new entry and incipient competition to the vitality of the marketplace; this Court's precedents apply the antitrust laws to protect such competition. In *United States v. El Paso Natural Gas Co.*, 376 U.S. 651, 662 (1964), the Court ordered El Paso Natural Gas to divest Pacific Northwest, which it had acquired. The Court found that the acquisition lessened competition even though Pacific Northwest had not yet sold any natural gas in competition with El Paso in the California relevant market. Pacific Northwest had been on the verge of doing so, and had entered into negotiations and a tentative agreement for a supply contract with a prospective customer. *Id.*, at 660-61. In *United States v. Marine Bancorporation*, 418 U.S. 602, 623-25 & n.24 (1974), the Court discussed the El Paso ruling, and, notably, described El Paso as an "actual competition rather than a potential competition case."[16]

In Sherman Act Section 1 cases, courts often apply strict scrutiny to restraints directed at the actions of firms in

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[16] See also *In re Brunswick Corp.*, 94 F.T.C. 11 (F.T.C. 1979) (Pitofsky, C.), *aff'd on other grounds sub nom., Yamaha Motor Co. v. FTC*, 657 F.2d 971, 980-81 (8th Cir. 1981), *cert. denied*, 456 U.S. 915 (1982). The FTC had determined that Brunswick's venture with Yamaha unlawfully lessened "actual competition" in the United States outboard motor market, even though Yamaha had made no sales into the country. The Eighth Circuit held that the joint venture unlawfully lessened "actual potential competition."

potential competition, recognizing that such restraints can be horizontal in character, even though actual competition, in the sense of commercial business operations in the same relevant market, has not yet occurred. For example, in *Palmer v. BRG*, 498 U.S. 46 (1990) (per curiam), defendants argued that vertical analysis was appropriate because they were only potential and not current competitors, and because the challenged dealings between them were vertical. The Eleventh Circuit agreed, but this Court reversed, finding the challenged covenant to be "illegal on its face." *Id.*, at 50.[17] *See also United States v. Reicher*, 983 F.2d 168, 170 (10th Cir. 1992) (applying horizontal *per se* standard although one of the two competitors did not have the capacity to perform the contract); *United States v. MMR Corp.*, 907 F.2d 489, 498 (5th Cir. 1990) (affirming decision that company lacking capacity to enter the market was a competitor, because it "was a competitive threat"); *Engine Specialties, Inc. v. Bombardier Ltd.*, 605 F.2d 1, 11 (1st Cir. 1979) (holding that a contract not to compete between a manufacturer and potentially competing distributor was *per se* illegal).

The Third Circuit's notion that two facilities are not competitors for purposes of antitrust analysis until the second facility opens its doors is peculiar and contrary to past decisions and common sense. The antitrust laws must protect doctors desiring to affiliate with ASCs against a dominant hospital's anticompetitive acts as soon, for example, as the physician's definite steps toward opening or providing services through an ASC makes him or her a potential or incipient competitor. As the Court explained in

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[17] *See also Palmer v. BRG*, 874 F.2d 1417, 1432-33 (11th Cir. 1989) (Clark J., dissenting) ("It is firmly established that entities in a seemingly vertical relationship may be capable of horizontal restraints if they are actual or potential competitors.").

El Paso, a firm's competitive significance in a market "is determined by the nature or extent of that market and by the nearness of the absorbed company to it, that company's eagerness to enter that market, its resourcefulness, and so on." 376 U.S. at 660. Under this analysis, "Pacific Northwest's position as a competitive factor in California was not disproved by the fact that it had never sold gas there." *Id.* By any measure, Dr. Gordon was a competitor of the Hospital when the challenged restraints occurred.

Opening an ASC can be an arduous process. The CON procedure in some states, such as Pennsylvania's during the time in question, was highly regulated, costly, and time-consuming. Hospitals often hold the key for ASC entry, as the federal government and many state regulatory agencies require physicians who seek to open or work at an ASC to have privileges at a hospital. In this way, ASCs are particularly vulnerable when they are still nascent, and the doctors who support them are then most in need of antitrust protection. A finding that antitrust protections for ASCs and doctors who work with them do not fully ripen until their doors are actually open for business poses severe risks for ASCs, for competition, and for consumers.

Appropriate antitrust analysis of hospital-physician interactions can be complicated. Questions regarding applicability of the *per se* rule and of "quick look," "sliding scale" or full-blown rule of reason standards can arise. The answer to these questions may depend on a variety of factors, and the mere fact that parties are in some regards competitors does not condemn any and all agreements between them necessarily to *per se* or "quick look" treatment. It is equally evident, though, that to the extent an agreement's horizontal character makes a difference in antitrust analysis, it is wholly unsound to decide that question by application of an all-or-none "are they

competitors" test that turns on whether the target of the restraint has yet opened his or her doors.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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IN THE

Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C., a Corporation; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC., a Corporation,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

ON A PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

MOTION TO FILE BRIEF AMICI CURIAE AND BRIEF OF AMERICAN OSTEOPATHIC ASSOCIATION AND PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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MOTION FOR LEAVE TO FILE AMICI CURIAE BRIEF OF THE AMERICAN OSTEOPATHIC ASSOCIATION AND PENNSYLVANIA OSTEOPATHIC MEDICAL ASSOCIATION

The American Osteopathic Association ("AOA") and Pennsylvania Osteopathic Medical Association ("POMA") (collectively the "*Amici*") respectfully move this Court, pursuant to Rule 37.2(b), for leave to file a brief as *Amici Curiae* in support of the petition for a writ of certiorari to the United States Court of Appeals for the Third Circuit. Petitioners have consented to the filing of this brief, but respondent has declined to consent, thereby necessitating this motion. A copy of the proposed *amici curiae* brief is attached.

As more fully explained at pages 1-2 of the attached brief, under "Interest of *Amici Curiae*," the AOA was founded in 1897 and is the national association that serves more than 56,000 osteopathic physicians practicing in the United States. The POMA was founded in 1903 and is the state association for osteopathic physicians who practice in Pennsylvania. Osteopathic physicians have historically been subjected to discrimination in the medical community, particularly in the area of credentialing and privileging at hospitals.

Amici seek leave to file this brief on the narrow question of the statutory construction of immunity under the Health Care Quality Improvement Act ("HCQIA"). In passing the HCQIA, Congress sought to promote and protect peer review of Medical professionals. At the same time, Congress also sought to prevent the peer review process from being abused by creating exceptions to the otherwise blanket immunity hospitals could enjoy under the HCQIA. The Third Circuit's decision threatens to eliminate these protections.

The *Amici* are uniquely positioned to address the HCQIA statutory construction question presented from the perspective of the minority physician population, a population that the exceptions to immunity under the HCQIA were originally enacted to protect. The *Amici* believe they can assist the Court by demonstrating how the Third Circuit's ruling reads the exception Congress enacted to protect them, and others similarly situated, out of the statute; and how its approach shifts the burden of proof in establishing HCQIA immunity from the movant, to the victim of an improper peer review, of the type *Amici's* members may face.

For these reasons and those set out in the accompanying brief, AOA and POMA hereby move the Court to allow them to appear as *Amici Curiae*, and to submit their brief urging the Court to grant the Petition and reverse the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted this 13th day of March, 2006.

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INTEREST OF *AMICI CURIAE* [1]

The American Osteopathic Association ("AOA") is the national association for osteopathic medicine. The AOA serves as the professional association for more than 56,000 osteopathic physicians ("Doctors of Osteopathic Medicine or "DOs") practicing in the United States. The AOA is also recognized by the United States Department of Education as the accrediting agency for osteopathic medical schools and also accredits osteopathic graduate medical educational programs (i.e., internships, residencies and fellowships) and continuing medical education programs throughout the United States. The Pennsylvania Osteopathic Medical Association ("POMA") is the state association for the approximately 6,000 osteopathic physicians who practice in Pennsylvania. POMA has the largest number of osteopathic physicians of any state and Pennsylvania. There are two osteopathic medical schools in Pennsylvania.

Osteopathic physicians (Doctors of Osteopathy or DOs) are eligible to be licensed for the full scope of medical and surgical practice in every state in the United States, but osteopathic physicians remain a minority of the physician work force, accounting for roughly 8% of that work force. Historically, DOs have been subject to discrimination in the medical community, particularly where economic forces bring DOs into competition for patients. The discrimination has been most prevalent in the area of credentialing and privileging at hospitals. E.g., *Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984); *Welchin v. Tenet Healthcare Corp.*, 366 F. Supp. 2d 338 (D.S.C. 2005); *Fritz v. Huntington Hospital*, 39 N.Y.2d 339 (N.Y. 1976); *Greisman v. Newcomb Hospital*, 40 N.J. 389 (N.J. 1965). While ethical principles indicate that hospital medical staff privileges should not be based on "personal friendships, antagonisms, jurisdictional disputes,

1. Counsel for a party did not author this brief in whole or in part. No person or entity, other than the *Amici Curiae*, has made a monetary contribution for the preparation and submission of this brief.

or fear of competition" (AMA Code of Medical Ethics, Section 4.07 (2004)), credentialing, privileging and peer review decisions can, and do, turn on issues of competition disguised as quality of care issue.

Because it is essential for osteopathic physicians to be able to admit their patients into hospitals and for osteopathic specialty physicians to have access to hospital facilities, osteopathic physicians must be able to secure relief in the event that peer review processes are abused for economic advantage of competing physicians. Until the Third Circuit's decision below, the exceptions from immunity Congress provided under the Health Care Quality Improvement Act ("HCQIA") afforded that protection and permitted health care providers in the minority (such as osteopathic physicians and podiatrists), to sue for, *inter alia*, antitrust violations, for actions primarily based on the physician's association with a particular class of health care professional. The Court should grant certiorari, reverse the decision below, and confirm that a "reasonable belief" that an anti-competitive action was taken in the interest of patient care does not void the plain statutory exceptions Congress provided.

SUMMARY OF ARGUMENT

The AOA and POMA petition in support of certiorari here on the narrow issue of whether a "reasonable belief in furtherance of quality health care" should be allowed to override the enumerated exceptions to HCQIA-conferred immunity, and whether the burden of establishing such an immunity falls on a plaintiff. The AOA and POMA respectfully submit that the reasonable belief should not override the law and the burden to establish immunity should remain with a defendant. Certiorari should be granted to confirm this precisely so that health care entities, such as hospitals, do not use the Third Circuit decision below to attempt to shield anti-competitive actions from liability by placing the decisions in the guise of a "reasonable belief."

The stakes are high here not only for physicians who may be viewed as competitors by hospitals, but also for health care providers in the minority such as osteopathic physicians. Hospitals could, for example, based on the Third Circuit decision, take action against osteopathic physicians and order other physicians or hospital employees not to refer to osteopathic physicians or associate with them because of a purported "concern for patient health and welfare." Under the Third Circuit's ruling, such blatantly anti-competitive behavior would be immune so long as the hospital based its actions upon the "reasonable belief" that they were acting in furtherance of the quality of health care. (Petitioner's Appendix 31-32). This interpretation strips the law of any practical effect and reads the exceptions out of the law. This dangerous precedent eviscerates Congressional intent and puts health care practitioners and health care itself at risk. Under Supreme Court Rule 10(c) "it is an important question of Federal law that has not been, but should be, settled by this Court."[2]

The Third Circuit's decision also contradicts other Circuit decisions and established Supreme Court precedent that placed the burden of establishing an affirmative defense, such as immunity, rests on the defendant. Again, the decision contradicts the plain language of the statute that creates a presumption that the health care entity had a reasonable belief it was acting in furtherance of quality health care only if its actions first qualify as a "professional review action." The

2. Respondent may suggest there is no circuit split on this issue and, therefore, certiorari should not be granted. *Amici* respectfully submits there is no split because the decision on this issue directly contravenes the plain language of the statute. Waiting for "percolation" will only allow the precedent to create more harm and is not a reason to permit it to stand. The decision does contradict established Supreme Court law on statutory construction and other Circuit decisions on where the burden of proving immunity lies.

statute establishes no presumption that any act is a professional review action or that it is a plaintiff's burden to show it is not. Certiorari should be granted.

I. CERTIORARI SHOULD BE GRANTED BECAUSE THE RULING BELOW READS THE EXCEPTIONS TO IMMUNITY OUT OF THE STATUTE.

A. A Statute Is Read to Give Effect to All Its Parts.

The Health Care Quality Improvement Act ("HCQIA") is a statute that grants health care delivery organizations immunity from money damage suits based on defined peer review activities. When Congress enacted the HCQIA, however, it recognized that hospitals and other health care organizations had a long history of abusing the credentialing and peer review processes for anticompetitive and exclusionary purposes, including the exclusion of physicians in a particular class of health care professionals such as DOs. *See, e.g., Weiss v. York Hospital*, 745 F.2d 786 (3d Cir. 1984). As a result, the HCQIA contains a series of exceptions that deny immunity to a health care entity when a disciplinary action is primarily based on a physician's association with a class of professional (like DOs) or a physician's competitive conduct such as advertising or patient solicitation, both of which have been traditionally attacked as "unprofessional" by interested parties in the hardscrabble world of healthcare delivery. The decision below, if allowed to stand, makes those statutory exceptions created by Congress a dead letter.

The relevant portions of the HCQIA at issue here are plain on their face. Hospital disciplinary actions that amount to a "professional review action" are entitled to immunity if the professional review action was taken in furtherance of quality health care and meets other due process requirements. The HCQIA, at 42 U.S.C. § 11151(9), defines a "professional review action" as:

> (9) [A]n action or recommendation of a professional review body which is taken or made

> in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may effect) adversely the clinical privileges . . . of the physician . . .

The definition of a "professional review action," however, then goes on to exclude or "carve out" certain actions from the scope of a "professional review action":

> [A]n action is not considered to be based on the competence or professional conduct of a physician [and thus is not a professional review action] if the action is primarily based on (A) [text omitted here]
>
> (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business . . .
>
> (C) [text omitted here]
>
> (D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or . . .
>
> (E) [text omitted here]

42 U.S.C. § 11151(9).

As the language above plainly reveals, Paragraphs 9(D) and 9(B) deny a hospital immunity when it decides to discipline a physician primarily for competitive conduct or for associating with or delegating authority to osteopathic physicians and other classes of practitioners. In those circumstances, the action is not considered a "professional review action" under the statute and, consequently, its

immunity does not apply. The exclusions, by definition, apply even if the hospital reasonably believed that the forms of conduct adversely affected patient welfare. Put differently, HCQIA does not grant hospitals immunity if they use their control over admitting privileges to prevent physician collaboration with other types of health care providers or for engaging in other competitive conduct.

The Third Circuit ruled below that whether Petitioner's actions were intended to solicit or retain business under § 11151(9) was irrelevant because:

> even when the solicitation exception is in play, immunity will be judged by . . . whether the Hospital based its actions upon the reasonable belief that they are in furtherance of quality healthcare.

Pet. App. 31-32. Thus, according to the Third Circuit, whenever a hospital has a "reasonable belief" that it is furthering quality health care, the stated exceptions to immunity in § 11115 do not apply and the hospital is still entitled to immunity.

This conclusion is inconsistent with the plain language of § 11151(9) and reads all of the exceptions out of the HCQIA. To constitute a "professional review action" in the first place, a hospital must show that it based its peer review action on the physician's "competence or professional conduct . . . which conduct affects or could affect adversely the health or welfare of a patient or patients." 42 U.S.C. § 11151(9).

Congress did not intend this outcome. After careful debate of concerns raised by physicians and the public,[3]

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3. *See, e.g.*, Report 99-103, Part I, Chairman Dingell, Committee on Energy and Commerce, H.R. Sep. 26, 1986; *cf* H.R. Rep. 99-903, pt. 1, at 21 (1986); Testimony of Sidney M. Wolfe, M.D., Director, Public Citizen Health Research Group, Oct. 6, 1986, House Judiciary Committee Hearings on H.R. 5540.

Congress decided a hospital could *never* make that showing if the decision was based primarily on one of the four exceptions, including competitive conduct and association with other classes of providers, such as osteopathic physicians, psychologists and others. Holding a hospital can avoid § 11151(9)'s carve-out if it reasonably believes that such association or certain competitive conduct would adversely affect patient welfare is to say that the statutory exceptions do not apply to any action that satisfies the general definition of a professional review action could qualify for the statutory exceptions. Under the Third Circuit's interpretation, the rule swallows the exception.

Just two years before passage of the HCQIA, in *Weiss v. York Hospital*, 745 F.2d 786 (3d. Cir. 1984), the Third Circuit affirmed an antitrust judgment against a Pennsylvania hospital for using its credentialing mechanism to exclude DOs as a class. As Congress debated exceptions to the immunities it was considering for hospitals, that case was part of the public record informing the debate. Whether the exclusion of osteopathic physicians was unlawful was subject to evidence and scrutiny by a court. However, with complete immunity, the hospital and its conspirators would not have been subject to scrutiny in the first instance. While peer review is important and hospitals should be generally immune, an exception was needed, and Congress provided it, with § 11151(9). Under the Third Circuit's analysis in the case below, there may well have been no *Weiss v. York Hospital*, and in that case discrimination against osteopathic physicians could continue to this day.

Similarly, the health care world is today locked in a competitive battle between the general acute care setting and specialized facilities that are sometimes owned and operated by the competitor of a hospital or certain of their closely allied physicians. (*See, e.g., Baptist Health v. Murphy, et al.*, 2006 Ark. Lexis 58, 2006 WL 242670 (Ark. Feb. 2, 2006)). Hospitals are using their credentialing mechanism to lock out competitors, sometimes defending their actions in the guise of their expansive view of what best furthers the delivery of quality care.

In these types of confrontations, hospitals have had to answer for their anticompetitive misconduct in a court of law and have not benefited from a blanket immunity never intended by Congress. If allowed to stand, the decision in the Third Circuit below creates just such an expanded immunity. A hospital's reasonable belief that its actions furthered quality healthcare would trump Congressionally mandated exceptions to immunity. These examples illustrate the wisdom of not tinkering with traditional rules of statutory construction, even assuming the set of facts the Third Circuit relied upon below.

The Supreme Court has consistently held that, as a fundamental matter of statutory construction, a statute should be read to give effect to all its parts, where possible. *E.g.*, *Cooper Industries, Inc. v. Aviall Services, Inc.*, 543 U.S. 157, 158 (2004); and *Duncan v. Walker*, 533 U.S. 167, 174 (2001). Here, the HCQIA can be read to give effect to both § 11151(9) and § 11112 if the "reasonable belief" requirement and presumption of § 11112 only applies after the court has determined, under § 11151, that an action is a "professional review action," which requires a determination that the action does not fall within one of the stated exceptions set forth in § 11151(9)(A)-(E). The Third Circuit did not address this logical and legal failing in its decision. No other court has construed these statutory sections like the Third Circuit did. The Court should grant certiorari to clarify how the law is to be read and to give effect to all its parts.

B. Words Are Not Read Into A Plain Statute.

The Third Circuit's decision effectively amends § 11112 to add that "it will be presumed that an action under § 11151(9)(A)-(E) is still a 'professional review action' if the action is taken with a reasonable belief it was done in furtherance of quality health care."

But §§ 11111, 11112 and 11151 do not say that. Rather, § 11151 defines a "professional review action" and identifies five exceptions (in § 11151(9)(A)-(E)) that are not considered to be based on competence or professional conduct and therefore are not "professional review actions." § 11112 then identifies how defined "professional review actions" must be taken and the presumptions that apply. Finally, § 11111 provides a limited immunity for damages for "professional review actions" as defined in § 11151 and taken in accordance with § 11112.

If Congress intended the immunity of § 11111 to apply to the exceptions identified in § 11151(9)(A)-(E) in situations where the review action was made with a reasonable belief it was furthering quality care, it easily could have expressed just that, as it did in § 11112. It did not. The inference and legal effect from Congress' failure to do so is clear. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002) (when Congress includes particular language in one section of a statute but omits it in another section of the same act, it is generally presumed that Congress acts intentionally and purposely in the disparate exclusion); *Id. K. P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 118 (2004). Under the established rules of statutory construction, the Third Circuit's "reasonable belief" gloss cannot be applied to the enumerated exceptions to immunity of § 11151. The Court should grant Certiorari.

C. Even If HCQIA Was Not Clear On Its Face The Legislative History Directly Contravenes The Third Circuit's Decision.

The only way the Third Circuit could have read a "reasonable belief" gloss onto the exceptions of § 11151(9)(A)-(E) would have been to find the language ambiguous on its face and then rely on extrinsic evidence, such as the legislative history, to determine its meaning. Indeed, this is the very analysis the Third Circuit conducted with respect to the preamble language of § 11151:

> The plain language of the statute indicates the breadth of 'conduct' encompassed within the definition of 'professional review action'. . . .

Pet. App. 27. The Third Circuit also analyzed the preamble language in the alternative, assuming it was ambiguous, by looking to the legislative history. Pet. App. 27-28. But the Third Circuit failed to conduct that same analysis with respect to its interpretation of the exceptions in § 11151(9)(A)-(E). The meaning of those exceptions is just as plain as the "conduct" defined as "could affect adversely the health and welfare of a patient." Thus, the "reasonable belief" gloss should not have been applied to the exception. More importantly, the legislative history concerning the exceptions confirms the exceptions are absolute.

When HCQIA was debated, professional associations and the United States sought to assure that the proposed immunity of HCQIA would not empower hospitals to exclude classes of practitioners or inhibit competition. The Subcommittee on Civil and Constitutional Rights observed that with the increasing competitive pressures in the health care industry

> "peer review poses the risk of preventing or discriminating against other health providers from full economic participation in the marketplace, (which) is no different than any other illegal restraint of trade." *See* 132 Cong. Rec. H9954-01, 1986 WL 788373 (daily ed. Oct. 14, 1986) (statement of Rep. Edwards).

As a result of this concern, the Act contains exclusions: disciplining a physician for practicing with a DO (*See*, Exclusion 9(D)) or, as here, for competitive acts to solicit or retain business (*See*, Exclusion 9(B)). While a hospital could present evidence that it had a good faith belief, for instance, that a physician should not associate with a DO, it does not

receive HCQIA immunity when it disciplines a physician for doing so.[4]

Congressman Waxman made it clear during discussion of the HCQIA bill that the identified categories of § 11151(9)(A)-(E) were completely excluded from the protections of the Bill:

> I appreciate that any form of immunity raises defense concerns about the potential for mischief that might be visited by doctors on their colleagues for improper reasons . . . I am now convinced that we have addressed every legitimate objection that has been raised to the bill. As redrafted, our bill applies only to professional review actions based on the competence or conduct of an individual physician. *We completely exclude from the protections of the bill*, any disciplinary action based on a doctor's advertising . . .

Health Care Quality Improvement Act of 1986: Hearing on H.R. 5540 Before the Subcomm. on Civil Rights and Constitutional Rights of the Comm. on the House Judiciary, 99th Cong., 2d Sess. (1986) (statement of Hon. Henry A. Waxman, sponser of H.R. 5540) (emphasis added).

Mr. Dingell, in Committee hearings on the bill, confirmed Congress' intent to provide absolute exclusions for actions based on, *inter alia*, activities with regard to classes of health care practitioners. The "reasonable belief"

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4. The Third Circuit noted below that one of the purposes of HCQIA was to improve the quality of medical care by restricting the ability of physicians who have been found to be incompetent from repeating malpractice by moving from state to state without discovery of such finding. App. 23; 42 U.S.C. § 11101. That purpose is not advanced in any way by the decision below reading a "reasonable belief" gloss onto the pro-competitive exceptions to the definition of a professional review action.

standard is not discussed nor otherwise raised in the entire legislative history of the act to avoid the effect of the exclusions:

> In addition, the Committee has carefully delineated circumstances which would not be considered to be based on competence or professional conduct. These include actions based on one's joining or not joining a professional society; on one's fees; on advertising or otherwise lawfully competing for business; on the economic organization of one's practice; or on one's activities with regard to health care practitioners who are not physicians . . . the Committee heard concerns from several groups that this area presented the greatest potential for abuse of the professional review process for economic or other reasons under the guise of improving the quality of health care. Accordingly, the Committee chose to restrict the protections under this legislation to actions by physicians against other physicians who do not meet reasonable tests of competence or professional behavior. **Professional review actions against physicians for reasons excluded from this legislation or those against other health care practitioners shall continue to be judged under all applicable law**.

H.R. Rep. No. 99-903, pt. 1, at 21 (1986) (emphasis added).

Certiorari should be granted to confirm there is no "reasonable belief" basis to void the exceptions to § 11151(9), and to effectuate Congress' clear intent.

II. CERTIORARI SHOULD BE GRANTED BECAUSE THE RULING BELOW IMPROPERLY SHIFTS THE BURDEN TO PLAINTIFFS TO ESTABLISH THE IMMUNITY DOES NOT APPLY.

In the decision below, the Third Circuit observed:

> Of course, as with *any challenge* to the applicability of immunity to a professional review action, the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action. 42 U.S.C. § 11112.

App. 32 (emphasis added).

This circular formulation misses the point that the question before the Court was whether this was a professional review action, as defined by Congress, at all. As significantly, it: contradicts established law that the burden is on the party raising an affirmative defense; suggests that all hospital review activities constitute "professional review actions" within the meaning of the statute and thus are entitled to a burden-shifting presumption of immunity; and threatens the very policies that Congress sought to achieve by establishing limits to hospital power through the exceptions enumerated in § 11151(9)(A)-(E).

A. Immunity is an affirmative defense, the burden of which is on the party raising it.

There can be little doubt that immunity is an affirmative defense, and as such, the burden of proving such a defense rests on the party raising it. *E.g.*, *K. P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 120, 125 S. Ct. 542, 549 (2004); *Ironside v. Simi Valley Hosp.*, 103 F.3d 482, 484 (6th Cir. 1996); *Yeager's Fuel v. Pennsylvania Power & Light Co.*, 22 F.3d 1260, 1266 (3d Cir. 1994). By holding that in "*any challenge* (emphasis added) to the applicability of immunity to a professional review action,

the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action," the Third Circuit expressly contradicted this established rule of law, and created a conflict with the Court and other circuit decisions. App. 32.

For instance, under the Third Circuit's view, any time a physician challenges the suspension or revocation of medical staff privileges, a hospital would merely need recite that its actions are immune under § 11111(a) as "professional review actions" taken in furtherance of patient quality of care; the burden would then shift to the physician to prove by a preponderance of the evidence that the activity did not constitute a "professional review action" as defined in § 11151(9). On the contrary, established law requires that the hospital make a prima facie showing that it meets the requirements of § 11151(9) and does not fall within one of the five statutory exceptions enumerated in (A)-(E). Once the hospital offers proof that its actions constitute "professional review actions," it has met its initial burden in raising its affirmative defense of immunity. The physician then must overcome the hospital's initial showing by proving by a preponderance of the evidence, that the requirements of § 11112(a) have not been met, and thus the hospital is not entitled to immunity under the HCQIA.

The Third Circuit erroneously places the burden on the physician when it should be placed on the hospital pursuant to raising an affirmative defense of immunity from the physician's anti-trust challenges. The Third Circuit stands alone in its interpretation of HCQIA. No other circuit court has held that the burden is on the physician to prove that the hospital was not engaged in "professional review action" as defined in § 11151(9)(A)-(E). The Third Circuit's decision is contrary to established law and the plain language of a Congressional Act. Certiorari should be granted to address this split of authority and to clarify the burden of proof in HCQIA immunity.

B. There is no presumption in § 11151.

The Third Circuit also reads in additional terms not present in the plain language of the statute. By stating that "the burden is on the physician to overcome the presumption that the hospital was engaged in a professional review action," the Third Circuit effectively amends § 11151(9) to add that where a defendant hospital argues that an activity was made in furtherance of patient quality of care it will then be presumed that it did not fall within the exception of § 11151(9)(A)-(E). This interpetation is contrary to the plain language of the statute, the legislative history and statutory rules of construction.

As the presumption is provided only in § 11112(a) and states that if a "professional review action" (as defined in § 11151(9)) is taken, then it will be presumed to have been taken:

> (1) in the reasonable belief that the action was in furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of subparagraph (3).

The Third Circuit disregards the question of whether the hospital's actions in the first instance constitute a "professional review action" and instead applies the presumption in § 11112(a) to § 11151(9)(A)-(E). If

Congress had intended for the presumption under § 11112(a) to apply to a "professional review action" under § 11151(9), it would have expressed it as such. As discussed in section I.B. above, the inference and legal effect from Congress' failure to do so presumes that Congress excluded the presumption from the definition of a "professional review action" intentionally and purposely. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002); *K.P. Permanent Make-Up, Inc. v. Lasting Impression I, Inc.*, 543 U.S. 111, 118, 125 S. Ct. 542, 548 (2004).

By reading in a presumption that is not provided in the plain language of the statute, the Third Circuit has effectively read the exceptions provided in § 11151(9)(A)-(E) out of the HCQIA. As described in section I.C. above, the legislative history demonstrates that the exceptions were carefully drafted in order to exclude particular activities, such as associating with a particular class of health care provider or soliciting for business. These activities were expressly excluded from the definition of "professional review actions" because Congress determined they were too historically fraught with anticompetitive and political overtones to be a proper basis for reviewing the competence or professional conduct of a physician. In order for the statutory exceptions to be given effect, as intended by Congress, the Court should grant certiorari to clarify this issue.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted and the case held.

Respectfully submitted,

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In The Supreme Court of the United States

ALAN D. GORDON, M.D.; ALAN D. GORDON, M.D., P.C.; MIFFLIN COUNTY COMMUNITY SURGICAL CENTER, INC.,

Petitioners,

v.

LEWISTOWN HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

MOTION TO FILE BRIEF AMICUS CURIAE AND BRIEF OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION, THE AMERICAN ACADEMY OF OPHTHALMOLOGY, THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY, THE AMERICAN COLLEGE OF SURGEONS AND THE CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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MOTION TO FILE BRIEF *AMICUS CURIAE* OF THE FEDERATED AMBULATORY SURGERY ASSOCIATION, THE AMERICAN ACADEMY OF OPHTHALMOLOGY, THE PENNSYLVANIA ACADEMY OF OPHTHALMOLOGY, THE AMERICAN COLLEGE OF SURGEONS AND THE CALIFORNIA MEDICAL ASSOCIATION

The Federated Ambulatory Surgery Association (**FASA**), the American Academy of Ophthalmology (**AAO**), the Pennsylvania Academy of Ophthalmology (**PAO**), the American College of Surgeons (**ACOS**) and the California Medical Association (**CMA**) respectfully move for leave to file the attached *amicus curiae* brief, pursuant to Supreme Court Rule 37.2(b), in favor of granting the petition for a writ of *certiorari*.

FASA, a nonprofit organization, is the nation's largest ambulatory surgery center (**ASC**) association. ASCs are facilities where physicians perform surgeries that do not require hospital admission. FASA represents more than 1,800 ASCs nationwide, the physicians and other professionals who provide care in such centers and their patients.

AAO, a nonprofit organization, is the largest national membership association of ophthalmologists. AAO has approximately 28,000 members worldwide. More than 90 percent of practicing ophthalmologists are members of AAO. PAO, a nonprofit organization, is the membership association of ophthalmologists in Pennsylvania, with over 500 members. ACOS, a nonprofit organization, is a scientific and educational association of surgeons that was founded in 1913. Members of ACOS are referred to as "Fellows." The letters FACS (Fellow, American College of

Surgeons) after a surgeon's name mean that the surgeon's education and training, professional qualifications, surgical competence and ethical conduct have passed a rigorous evaluation and have been found to be consistent with the high standards established and demanded by ACOS. ACOS currently has more than 64,000 Fellows, including more than 3,700 Fellows in other countries and more than 5,000 Associate Fellows, making it the largest organization of surgeons in the world. CMA, a nonprofit organization, is California's largest medical professional association. CMA represents more than 30,000 physicians, in all specialties, practicing in California. Many of the members of AAO, PAO, ACOS and CMA have ownership interests or practice in ASCs, where they perform surgery as an extension of their office practices.

The members of FASA, AAO, PAO, ACOS and CMA are at the forefront of developing ASCs as cost-effective, high quality alternatives to hospital-based surgery. The first ASC opened in 1970. Today, more than 14 million surgeries are performed each year in over 4,500 ASCs. The vast majority of ASCs are owned by physicians, who invest in ASCs to obtain greater professional autonomy and control over their work environment and over the quality of care delivered to their patients.

ASCs offer improved technology, a non-institutional, friendly environment and more convenient locations, shorter wait times and lower patient coinsurance costs than their hospital competitors. U.S. Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition (July, 2004)* (***Improving Health Care Report***). At the same time, ASCs save insurers and government health care programs billions of dollars by obtaining lower fees and avoiding costly hospitalizations. A recent study of Medicare claims commissioned by FASA found that, on

average, claims cost $320 less in an ASC compared to hospital outpatient settings, and that the procedures performed in ASCs cost the Medicare program $1.1 billion less in 2005 than if the same procedures were performed in a hospital. Federated Ambulatory Surgery Association, *Medicare Payments for Procedures Performed in Ambulatory Surgery Centers Compared with Hospital Outpatient Departments* (Apr. 5, 2005), http://www.fasa.org/april5execsum.pdf. By providing a competitive alternative to hospitals, ASCs "enhance quality of care, lower prices, and improve access." *Improving Health Care Report,* Ch. 3 at 39-40.

FASA, AAO, PAO, ACOS and CMA urge the Court to grant the petition for a writ of *certiorari* to address two aspects of the Third Circuit's decision. First, this case squarely presents the question whether an entity must actually sell goods or services in the same relevant market to be a competitor under the Sherman Act. An entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. By limiting the availability of the Sherman Act's protections to actual competitors, the Third Circuit has effectively immunized antitrust conspirators and monopolists for anticompetitive activities so long as their competitor has not yet opened. As a consequence of the Third Circuit's holding, incumbents will find it far easier to quash new entry and to sustain market power. Prices will increase, and quality will decrease. It is often the potential entrant that needs the most protection. ASCs are frequently the entities most likely to enter a market in competition with an entrenched, incumbent hospital and are frequently the target of exclusionary practices by those very hospitals. ASCs are therefore particularly vulnerable to this decision.

The Third Circuit is alone in concluding that potential competitors are not subject and entitled to Sherman Act prohibitions and protections. No other Circuit, including the Third Circuit up until this case, refuses to extend Sherman Act prohibitions and protections to potential competitors. This Court should grant the petition for a writ of *certiorari* to make clear that an entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. Because FASA, AAO, PAO, ACOS and CMA represent a broad spectrum of ASCs and their affiliated physicians and other professionals, their perspectives on this issue should be helpful to the Court.

Second, this case raises the question whether a restraint on a physician's ability to disseminate truthful and non-deceptive information about his principal competitor can constitute a substantial effect on competition. The dissemination of truthful and non-deceptive information is critical to the efficient operation of health care markets. Restraints that limit the ability of physicians to disseminate such information have a significant effect on the ability of patients to choose optimal treatments for their illnesses and can cause significant market inefficiency or failure. The information restraints in this case, as written and as read by the Third Circuit, would have a substantial effect on competition. The Third Circuit is in conflict with this Court's decision in *California Dental Ass'n v. F.T.C.*, 526 U.S. 756 (1999) and the Ninth Circuit in *California Dental Ass'n v. F.T.C.*, 224 F.3d 942 (9th Cir. 2000). This Court should grant the petition for a writ of *certiorari* to make clear that information restraints that limit the ability of physicians to disseminate truthful and non-deceptive information, such as the ones in this case, do have a substantial effect on competition meriting a full consideration by the court and requiring strong

procompetitive justifications to sustain the restraints. Because FASA, AAO, PAO, ACOS and CMA represent a broad spectrum of physicians, their perspectives on this issue should be helpful to the Court.

In accordance with Supreme Court Rule 37.2, FASA, AAO, PAO, ACOS and CMA represent that they obtained written consent from counsel for the petitioners to file this brief *Amicus Curiae*. Counsel for the respondent declined to consent, however, thereby necessitating this motion. Sup. Ct. R. 37.2(b).

For these reasons and those set out in the accompanying brief, FASA, AAO, PAO, ACOS and CMA hereby move the Court to allow them to appear as *Amici Curiae* and to submit their brief urging the Court to grant the petition and reverse the decision of the Court of Appeals for the Third Circuit.

Respectfully submitted,

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March 13, 2006

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STATEMENT OF INTEREST[1]

The Statement of Interest of the Federated Ambulatory Surgery Association (**FASA**), the American Academy of Ophthalmology (**AAO**), the Pennsylvania Academy of Ophthalmology (**PAO**), the American College of Surgeons (**ACOS**) and the California Medical Association (**CMA**) are included in the Motion to File. FASA, AAO, PAO, ACOS and CMA have no interest in any party to this litigation or stake in the outcome of the case.

STATEMENT OF THE CASE

FASA, AAO, PAO, ACOS and CMA adopt the Statement of the Case presented by the petitioner. Pet. at 3-9. The petitioners consist of an ophthalmologist, Dr Alan Gordon (**Gordon**), his professional corporation, Dr. Alan Gordon M.D., P.C., and the surgical facility, Mifflin County Community Surgical Center, Inc. (**MCCSC**), he was attempting to open. The respondent is Lewistown Hospital (the **Hospital**), the incumbent, and only, hospital in Mifflin and Juniata counties in Pennsylvania. Gordon and another ophthalmologist, Dr. Paul Nancollas (**Nancollas**), were the only two ophthalmologists in Mifflin and Juniata counties. Pet. at 3. Both had privileges at the Hospital. On several occasions, Gordon was critical of Nancollas. The Hospital was concerned about Gordon's criticism. To suppress that criticism, the Hospital imposed certain restrictions on Gordon. These restrictions included information restraints

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[1] Pursuant to Supreme Court Rule 37.6, FASA, AAO, PAO, ACOS and CMA state that this brief has not been authored in whole or in part by counsel for a party and that no person or entity, other than Amici, their members or their counsel, has made a monetary contribution to the preparation or submission of this brief.

that barred Gordon from discussing the differences between him and Nancollas with patients:

> (2) ...[A] complaint or concern about any other member of the Medical-Dental Staff must be in writing addressed to either the President of the Medical Staff or the Chairperson of the Hospital, with a copy to the President of the Hospital...
>
> (3) You shall not call, or otherwise attempt to communicate with, the patients of any other ophthalmologist, or other physician practicing in the Hospital, for the purpose of commenting on the physician's training, skill or competence or the procedure performed by such physician. Furthermore, other than in response to a specific question or for the purpose of a referral, you shall not make any comment about any other ophthalmologist as part of your discharge instructions or at any time when dealing with patients who have been or will be treated at the Hospital.

App. at 10-11. The Hospital required Gordon to adopt the conditions to maintain his privileges at the Hospital. He required privileges or a transfer agreement with the Hospital to open MCCSC. App. at 83. Gordon was planning to open MCCSC at the time the information restraints were imposed. The Hospital knew he was trying to open MCCSC. *E.g.*, App. at 15.

The petitioners sued the respondent for violations of Sections 1 and 2 of the Sherman Act. App. at 2. Count I of the petitioners' complaint alleged that the information restraints constituted an unreasonable restraint of trade under Section 1 because they prevented Gordon from

competing in a physician services market for outpatient cataract surgery, inpatient eye surgery and emergency eye surgery, and prevented MCCSC from competing in a facility services market for outpatient cataract surgery. App. at 40. At the conclusion of a bench trial, the District Court ruled that the petitioners failed to sustain their burden of proving a *prima facie* case under a traditional rule of reason analysis and entered judgment for the Hospital on Count I. The petitioners appealed to the Third Circuit, claiming the District Court should have employed a "quick look" rather than a full rule of reason analysis. The Third Circuit disagreed with the petitioners, holding that the information restraints were "non-price vertical restraints between one hospital and one physician, which we have held is reviewed under the traditional rule of reason." App. at 41. In arriving at that conclusion, the Third Circuit stated that:

> This is especially true given the District Court's determination, with which we agree, that Gordon and the Hospital were not competitors in the relevant market in November 1995 [sic] when he agreed to the Conditions. ***His competition in the facility services market did not commence until MCCSC opened more than one year later.***

App. at 41 (emphasis added; Gordon agreed to the information restraints in 1996, not in 1995; Pet. at 24).

REASONS FOR GRANTING THE PETITION

FASA, AAO, PAO, ACOS and CMA urge the Court to grant the petition for a writ of *certiorari* to address two aspects of the Third Circuit's decision. First, this case squarely presents the question whether an entity must

actually sell goods or services in the same relevant market to be a competitor under the Sherman Act. The Third Circuit is alone in concluding that potential competitors are not subject and entitled to Sherman Act prohibitions and protections. No other Circuit, including the Third Circuit up until this case, refuses to extend Sherman Act prohibitions and protections to potential competitors. This Court should grant the petition for a writ of *certiorari* to make clear that an entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. Second, this case raises the question whether a restraint on a physician's ability to disseminate truthful and non-deceptive information about his principal competitor can constitute a substantial effect on competition. This Court should grant the petition for a writ of *certiorari* to make clear that information restraints that limit the ability of physicians to disseminate truthful and non-deceptive information, such as the ones in this case, do have a substantial effect on competition meriting a full consideration by the court and requiring strong procompetitive justifications to sustain the restraints.

I. THE SHERMAN ACT'S PROHIBITIONS AND PROTECTIONS APPLY TO POTENTIAL COMPETITORS LIKE ASCs.

A. The Sherman Act applies to both actual and potential competitors.

In *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972), the Court found a market allocation agreement between members of a regional supermarket association to be an illegal horizontal restraint even though the association members had never competed in the same market. The

Court clearly found the "restraint in this case [to be] a horizontal one" notwithstanding the fact that the member supermarkets were not actual competitors. *Id.* at 608; *see also Palmer v. BRG of Georgia*, 498 U.S. 46, 49 (1990) (citing *Topco* in support of the proposition that horizontal restraints exist even where parties have "never competed in the same market"); *Otter Tail Power Co. v. United States*, 410 U.S. 366, 378 (1973) (citing *Topco* to re-emphasize "the vice under the Sherman Act of territorial restrictions among potential competitors").

The Third Circuit itself has held that the Sherman Act applies to both actual and potential competitors. In *American Motor Inns, Inc. v. Holiday Inns, Inc.*, 521 F.2d 1230, 1242 (3d Cir. 1975), the Third Circuit, citing *Topco*, found Holiday Inn's practice of allowing existing franchisees effectively to veto a potential competitor's entry into its market to be a horizontal market allocation that violated the Sherman Act. Similarly, in *Evans v. S.S. Kresge Co.*, the Third Circuit explicitly stated that, before horizontal restraints can be declared unlawful, the court must determine whether the agreements imposing such restraints "were made between competitors, actual or potential..." 544 F.2d 1184, 1192 (3d Cir. 1976) (citing *United States v. Columbia Pictures Corp.*, 169 F. Supp. 888, 893 (S.D.N.Y. 1959) but ultimately finding the parties to the suit were neither actual nor potential competitors).

No other Circuit disagrees. In *Engine Specialties v. Bombardier*, 605 F.2d 1, 9 (1st Cir. 1979), the First Circuit sustained a challenge to a horizontal market allocation between Bombardier and Agrati. Bombardier wanted to enter into a manufacturing and distribution agreement with Agrati. Bombardier had developed a competitive minicycle prototype and was prepared to manufacture minicycles. Bombardier told Agrati that if Agrati did not agree to

participate in a manufacturing and distribution agreement with Bombardier, Bombardier would produce its own competitive minicycle. The First Circuit found the two to be "operating at the same horizontal level in the market" and so "competitors" even though Bombardier and Agrati never actually sold goods in competition with each other.

In *In re Terazosin Hydrochloride Antitrust Litigation*, 352 F. Supp. 2d 1279, 1314 (S.D. Fla. 2005), a district court found an agreement between Abbott Laboratories, a brand name drug manufacturer, and Geneva Pharmaceuticals, a generic drug manufacturer, that provided that Geneva would not produce a generic equivalent to Abbott's branded drug until a patent dispute between the two was settled to violate the Sherman Act. When it entered the agreement, Geneva had not yet begun producing a generic version of the drug. The district court stated that "no distinction is made between actual competitors (*i.e.*, those currently competing in the same market) and potential competitors." The court concluded that there was "no question" that the case "present[ed] a 'horizontal agreement.'" *Id.* at 1314 n. 34.

Similarly, in *In re Cardizem CD Antitrust Litigation*, 332 F.3d 896, 899 (6th Cir. 2003), *cert. denied sub nom. Andrx Pharmaceuticals, Inc. v. Kroger Co.*, 534 U.S. 939 (2004), the Sixth Circuit upheld a district court's decision that found illegal an agreement between Hoescht Marion Roussel, Inc. (**HMR**), the manufacturer of a prescription drug, and Andrx Pharmaceuticals, Inc. (**Andrx**). Like the agreement in *Terazosin Hydrochloride*, the *Cardizem* agreement provided that Andrx would refrain from marketing a generic version of the branded drug in exchange for quarterly payments from HMR. The court determined the agreement was an illegal "horizontal market allocation agreement" despite the fact that Andrx had not

yet begun manufacturing the generic equivalent. *Id.* at 900; *see also Wallace v. Free Software Foundation, Inc.*, 2005 WL 3239208, at *2 (S.D. Ind. Nov. 28, 2005) (characterizing horizontal price fixing agreements as "those made by competitors or potential competitors").[2]

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[2] A potential competitor can also suffer antitrust injury under Section 2. In *American Tobacco Co. v. United States*, 328 U.S. 781 (1946), the Court affirmed a jury's finding that three large tobacco companies had formed an illegal monopoly. The Court said that parties violate Section 2 when they "combine or conspire to acquire or maintain the power to exclude competitors from any part of [trade or commerce]... provided they also have such a power that they are able, as a group, to exclude actual or *potential competition* from the field..." *Id.* at 809 (emphasis added). The Third Circuit has also held that actual as well as potential competitors can suffer antitrust injury under Section 2. *E.g., LePage's Inc. v. Minnesota Mining & Mfg. Co.*, 324 F.3d 141, 155 (3d Cir. 2003) (finding the effect of company's bundled rebates was to "foreclose portions of the market to a potential competitor" and, accordingly, was anticompetitive such that the finding of a Section 2 violation was warranted), *cert. denied*, 542 U.S. 953 (2004); *SmithKline Corp. v. Eli Lilly & Co.*, 575 F.2d 1056 1063 (3d Cir. 1978) (holding that a market definition under Section 2 "must look at all relevant sources of supply, either actual rivals or eager potential entrants to the market"), *cert. denied*, 439 U.S. 838 (1978). *See also, e.g., United States Philips Corp. v. Windmere Corp.*, 861 F.2d 695 (Fed. Cir. 1988) (reversing lower court's directed verdict and ordering new trial on Section 2 claims due to evidence that company had engaged in predatory pricing in order to eliminate potential competitors), *cert. denied*, 490 U.S. 1068 (1989); *Fishman v. Estate of Wirtz*, 807 F.2d 520 (7th Cir. 1986) (finding corporation liable under Section 2 for refusing to lease stadium to a potential market entrant).

B. An entity must possess the intent and ability required to compete to be a potential competitor.

The Third Circuit did not address whether Gordon possessed the requisite intent and ability to be a potential competitor. The court merely concluded that Gordon was not a competitor until MCCSC opened. In *Terazosin Hydrochloride*, the district court found that a generic drug manufacturer became a potential competitor of the brand name manufacturer when it filed an Abbreviated New Drug Application (**ANDA**) to produce a generic version of a brand name drug. 352 F. Supp. 2d at 1314 n.34 ("the mere filing of an ANDA is sufficient evidence that generic drug companies are competitors of brand name manufacturers"); *see also United States v. Reicher*, 983 F.2d 168 (10th Cir. 1992) (defining "potential competitor" to include a company involved in a bid-rigging scheme that was incapable of actually performing the contract on which it placed the false bid); *United States v. MMR Corp.*, 907 F.2d 489 (5th Cir. 1990) (same).

By contrast, in *Transource International, Inc. v. Trinity Industries*, 725 F.2d 274 (5th Cir. 1984), the Fifth Circuit was asked to invalidate an agreement not to compete between two parties. The court refused because one of the parties had neither the capital nor the financial ability to compete and so could not be considered a potential competitor. *Id.* at 280.

Here, it would appear that Gordon had the intent and ability to be a potential competitor. Most importantly, Gordon filed a certificate of need (**CON**) petition with the Pennsylvania Department of Health in 1996. App. at 81. At the time, a CON was required for Gordon to open his ASC. The CON process, much like the ANDA process in *Terazosin Hydrochloride*, requires significant economic

commitment and a demonstration that the applicant has both the intent and the ability to operate a health care facility. Gordon also engaged in other activities that support the conclusion he was a potential competitor. Gordon spent three months actively pursuing his CON application with the Pennsylvania Department of Health. App. at 83-84. Gordon also solicited an anesthesiologist to be on staff at MCCSC. App. at 16. *See* Pet. 23-25. ASCs will typically engage in similar activities in order to enter a new market. If an ASC possesses the requisite capacity and has made positive steps similar to the ones Gordon made to open MCCSC, it should be treated as a potential competitor.

By limiting the availability of the Sherman Act's protections to actual competitors, the Third Circuit has effectively immunized antitrust conspirators and monopolists for anticompetitive activities so long as their competitor has not yet opened. It is often the potential entrant that needs the most protection. ASCs are frequently the entities most likely to enter a market in competition with an entrenched, incumbent hospital and are frequently the target of exclusionary practices by those very hospitals.

ASCs are a significant competitive counterbalance to entrenched, incumbent hospitals. The first ASC opened in 1970. Today, more than 14 million surgeries are performed each year in over 4,500 ASCs. The vast majority of ASCs are owned by physicians, who invest in ASCs to obtain greater professional autonomy and control over their work environment and over the quality of care delivered to their patients. ASCs offer improved technology, a non-institutional, friendly environment and more convenient locations, shorter wait times and lower patient coinsurance costs than their hospital competitors. U.S. Dep't of Justice & Federal Trade Comm'n, *Improving Health Care: A Dose of Competition* (July, 2004) (***Improving Health Care***

Report). At the same time, ASCs save insurers and government health care programs billions of dollars by obtaining lower fees and avoiding costly hospitalizations. A recent study of Medicare claims commissioned by FASA found that, on average, claims cost $320 less in an ASC compared to hospital outpatient settings, and that the procedures performed in ASCs cost the Medicare program $1.1 billion less in 2005 than if the same procedures were performed in a hospital. The FASA study also found that if procedures performed in hospital outpatient settings were instead performed in ASCs, Medicare would have saved nearly $1.6 billion more in 2005. Federated Ambulatory Surgery Association, *Medicare Payments for Procedures Performed in Ambulatory Surgery Centers Compared with Hospital Outpatient Departments* (Apr. 5, 2005), http://www.fasa.org/april5execsum.pdf. A government report from 2003 reached similar conclusions. *See* U.S. Dep't of Health and Human Services, *Payment for Procedures in Outpatient Departments & Ambulatory Surgical Centers* (Jan., 2003) (concluding that Medicare paid $1 billion more annually for procedures performed in hospital outpatient settings than it would if the same procedures were performed in ASCs). By providing a competitive alternative to hospitals, ASCs "enhance quality of care, lower prices, and improve access." *Improving Health Care Report*, Ch. 3 at 39-40.

ASCs are therefore particularly vulnerable to this decision. As a consequence of the Third Circuit's holding, incumbents will find it far easier to quash new entry and to sustain market power. Prices will increase, and quality will decrease. The Third Circuit is alone in concluding that potential competitors are not subject and entitled to Sherman Act prohibitions and protections. No other Circuit, including the Third Circuit up until this case,

refuses to extend Sherman Act prohibitions and protections to potential competitors. This Court should grant the petition for a writ of *certiorari* to make clear that an entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act.

II. THE INFORMATION RESTRAINTS HAVE A SUBSTANTIAL EFFECT ON COMPETITION.

Medicine is complex and beyond the expertise of the average person. Patients depend on their physicians to identify problems, offer choices about treatments and explain the comparative risks and benefits of different treatment options. A patient's choice about health care, and therefore her behavior in the market as a consumer, is a function of the information she receives from her physician. *Improving Health Care Report,* Executive Summary at 3, 6.

The dissemination of truthful and non-deceptive information is critical to the efficient operation of health care markets. *See, e.g., Virginia State Bd. of Pharmacy v. Virginia Citizens Council*, 425 U.S. 748, 765 (1976) ("[T]he free flow of commercial information is indispensable."). Restraints that limit the ability of physicians to disseminate such information therefore have a significant effect on the ability of patients to choose optimal treatments for their illnesses and can cause significant market inefficiency or failure. *Improving Health Care Report,* Ch. 3 at 17. *See also F.T.C. v. Indiana Federation of Dentists*, 476 U.S. 447, 459 (1986) ("no credible argument" that "making it more costly... [for customers] to obtain information needed for evaluating the dentists' diagnoses had... any procompetitive effect.").

In *California Dental Ass'n v. F.T.C.*, 526 U.S. 756 (1999), the Federal Trade Commission challenged a

professional association's "code of ethics" that limited members' ability to engage in truthful, non-deceptive advertising regarding price, particularly discounted fees, and the quality of dental services. The provision prohibiting advertising claims as to the quality of services, as enforced, provided that such claims are "not susceptible to measurement or verification; accordingly, such claims are likely to be false or misleading in any material respect." *California Dental Ass'n v. F.T.C.*, 128 F.3d 720, 724 (9th Cir. 1997), *rev'd*, 526 U.S. 756 (1999); *California Dental Ass'n v. F.T.C.*, 224 F.3d 942, 945 (9th Cir. 2000) (on remand). On remand from this Court, the Ninth Circuit specifically found that the information restraints were anticompetitive even though, in that case, the procompetitive benefits outweighed them. 224 F.3d at 949; *see* 128 F.3d at 729. Similarly, here, the Third Circuit should have found the information to be anticompetitive and should have required the hospital to present procompetitive justifications in order to sustain them.

By their plain language, the information restraints at issue here prohibited the comparative information sharing that patients need to make optimal health care choices. Condition 2 provides that any "complaint or concern about any other" physician at the Hospital must be made to the President of the Medical Staff or the Chairperson of the Hospital. Condition 2 does not appear to allow Gordon to voice a complaint or, more importantly, a concern, to any one else, including a patient or prospective patient. Condition 3 provides that Gordon will not "call, or otherwise attempt to communicate, with the patients of any other ophthalmologist, or other physician practicing in the Hospital," to "comment... on the physician's training, skill or competence or the procedure performed by such physician." Condition 3 continues by stating that

"[f]urthermore,..." Gordon will not comment about any other ophthalmologist as part of his "discharge instructions..." App. at 10-11. The word "[f]urthermore" signals that the preceding prohibitions on communicating are not being limited but expanded. The word "communicate" suggests more than just oral communication but any sort of communication including advertisements. These kinds of broad information restraints—unlimited by concerns regarding the truth or accuracy of the information being conveyed or the time or manner of such communications—would have a substantial effect on competition.

Both the District Court, App. at 153-156, and the Third Circuit, App. at 43-44, believe that the petitioners have construed conditions 2 and 3 of the information restraints too broadly. The Third Circuit, specifically, states that:

> Condition 3 only serves to chill Gordon's comments regarding other ophthalmologists as part of his discharge instructions or ***at any other time when dealing with patients who have been or will be treated by the Hospital***, excepting comments made "in response to a specific question or for the purpose of a referral." In light of Gordon's history, precluding him from making gratuitous statements at any time and in whatever fashion he deemed appropriate regardless of its impact or potential impact on patient health or welfare does not, standing alone, elevate Condition 3 to having anticompetitive effects. Likewise, as the District Court determined, Condition 2 only prohibited Gordon from commenting upon a particular surgical method as it relates to a particular physician, and not, as Gordon contends, from differentiating himself and his methods in surgical meetings.

App. at 43-44 (emphasis added). The court's interpretation of the information restraints appears to contradict their plain language. Even under the court's interpretation, though, the information restraints are quite broad. The Third Circuit notes that condition 3 would apply "at any other time when dealing with patients who have been or will be treated by the Hospital." The Hospital is the only hospital, and Gordon and Nancollas were the only ophthalmologists, in Mifflin and Juniata counties. Applying to all present and future patients of the Hospital, condition 3 actually affects a significant number of ophthalmic procedures.

The information restraints in this case, as written and as read by the Third Circuit, would have a substantial effect on competition. They are the same as the restraints the Ninth Circuit found anticompetitive in *California Dental Ass'n*, 224 F.3d at 949. Any restraint that in fact limits a physician's ability to communicate with his patients about his principal competitor (and the patients' most significant alternative) in a truthful and non-deceitful manner raises significant competitive issues. The information restraints will indeed "chill" the physician/patient relationship and "chill" the competitive process. *See, e.g.*, App. at 44. Physicians need to talk to their patients—to give patients the physicians' honest opinions in a full, frank and truthful manner. But, unlike the Ninth Circuit in *California Dental Ass'n*, *id.*, the Third Circuit never evaluated the procompetitive benefits of the information restraints. The Third Circuit is therefore in conflict with this Court. This Court should grant the petition for a writ of *certiorari* to make clear that information restraints that limit the ability of physicians to disseminate truthful and non-deceptive information, such as the ones in this case, do have a substantial effect on competition meriting a full

consideration by the court and requiring strong procompetitive justifications to sustain the restraints.

CONCLUSION

This Court should grant the petition for a writ of *certiorari* to make clear that an entity does not have to sell goods or services in the same relevant market to be a competitor under the Sherman Act. This Court should also grant the petition for a writ of *certiorari* to make clear that information restraints that limit the ability of physicians to disseminate truthful and non-deceptive information, such as the ones in this case, do have a substantial effect on competition meriting a full consideration by the court and requiring strong procompetitive justifications to sustain the restraints.

For the reasons stated herein, FASA, AAO, PAO, ACOS and CMA respectfully request that the Court grant the petition for a writ of *certiorari*.

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